Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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PD ———		1 - For Uppend Item Registrar		I,27,28a-t	, Per M	C830 4/2 Tilicate o	Death	aria ivi		3. No.	104	1200
Physicia	ın .	Decedent's Name (First, Middle	, Last)			Dob	inson		Date of Death Month	Day	Year	3. Time of Death
/Medic		Larry						4 D 15	April 1		004	0842 A
Examin	er	4a. Fecility Name (If not institution	give street and nu	mber)		4b. City, Towr	, or Location o	of Death		4c. Coun	ity of Death	
		2502 McHenry S	treet 6. Sex	7 Ago /lo um le	and high days	Baltime If Under 1 Ye		24 Hrs	9 Date of Birth		0 Rieb	place (State or Fore
Funeral		5. Social Security Number	0.59X 100MM 2□ F	7. Age (In yrs. Ia	Yrs.	Months Day		Min.	8. Date of Birth (Month, Day, 1	^{'ear)} 61	9. Birth	ntry) MD
Director		212-82-3457 Usual Residence of Decedent		42					11 10	01		110
* * #		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Lim
s 1 and 2 should be lied within 72 hours allet death with the marylating the and 27 de marked other than "natural", or Itama 23e or 28e-f show other traumatic event, the Medical Exercit artimat be notified at	tor	MD NA		Balt	timor	е						1 X Yes 2 □ f
28a	rec	10e. Street and Number				10f. Zip Code			10	g. Citizen o	f Whal Cou	intry?
39.0	0	2508 McHenry	Street				21223			U.	S.A.	
ms 2	Funeral Director	11, Marital Status	12. Was Dec	edent Ever in U.S	3. 13.	Was Decedent of	f Hispanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)		ece - Ameri	
or Its		1 X Never Married 2 ☐ Marri	Armed F ed 1 Yes If Yes, G	2 🕅 No	ĺ	ires, specily c 1 □ Yes 2 X N		1, Fuento	nican, etc.)		lack, White,	
- 1	1 by	3 Widowed 4 Divorced	Year or C	Dates:		1 1 1 1 1 2 2 2 1	io specify.			Spec	y. E	lack
netu	Completed	15. Decedent (Specify only highes			16a. Dece (Give	dent's Usual Oci kind of work do DO NOT use ret	cupation ne during most	t of worki	ng 1	6b. Kind of	Business/Ir	ndustry
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od of H	Be	17. Father's Name (First, Middle,							(First, Middle, M.		ame)	
1 Mer narke	2	Roosevelt Mi			405 44-10-				Robinson		- 04-4- 7	- Code)
is n		19a. Informant's Name/Relations		h a .a					Baltime			21230
m 27		Aretha Robin 20a. Method of Disposition	ison-Mot								n - City or T	
nent of H		1 Burial 2 ☐ Cremation		State		sition (Name of matory or other p	I .		- 47			
tment tant		'4 □Donation 5 □ Other (S)	•	Mt		n Ceme			7/04 B	altin	nore,	Md
Department of Health a Important: If item 27 is any injury or other training.		21. Signature of Funeral Service	7. Mon	pain	M 4	arch F 300 Wa	/A We.	št Ave,	Balti	nore	Mđ	21215
80		23a. Part1 Enter the disease, or shock, or heart failure. List	complications that	caused the death	. Do not ent	er the mode of o	lying, such as	cardiac o	r respiratory arres	t,		Approximate Interval Between
nysician		Immediate Cause (Final disease or condition		hine and a	lcohol	intoxicat	ion					Onset and Death
/Medical		resulting in death)	_ a	(or as a consequ								
xaminer		Secure the link and distance	b									
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or se a consequ	encs of):	_						
earr cerminate be executed attending physician and for use as the burial-transit	Examiner	that initiated events	c									
ician and burial-transit		resulting in death) Last	Due to	(or as a consequ	ence of):							
y sic	cal		d									
ng pl	Med	IF FEMALE:	T							7.74		
tendi r use	Physician/Med	23b. Was decedent pregnant in the past 12 months?		itcome of pregnar birth 2 ☐ Fetal		Ectopic pregna	ncy				Date of deliver	ery Day Year
he at	Sici	1 ☐ Yes 2 ☐ No	4∐Preg 9☐Unkr	nant at time of de nown	ath 5	Other (specify,					VIOLITI I	<i>Duy</i>
ine raw requires travine destricts the standing phy ale has been signed by the attending phy page 2 should be detached for use as the	Phy	9 Unknown							an- Bida-b		-1-1-1-1-1-1	the course of denth?
been signed to should be detailed to should	by	Part II. Other significant condition Cocaine Use	ins contributing to d	leath but not resu	liting in the u	nderlying cause	given in Part I.	•	1			the cause of death? bably 4 □Unkno
pino s uee	ted	- Carlie GC							T Tes	2 🖂 1100	3 🗆 🗀	Dably 4 Delikito
as b	Completed								24a. Was an autopsy		prior to co	opsy findings availal empletion of cause of
ate h	Й								perform		death?	2 □ No
certificate has b	Be (25. Was case referred to medical examiner?						of Death	(Check only one			
nis ce I dire	10	1XXYes 2 □ No	Hospital: 1	Inpatient 2 🗆 E	ER/Outpatier	nt 3 DOA	Other: 4 ☐ Nu	irsing Hor	me 5 Residen	ce 6 🔽	ther (Speci	M At Scel
fer th		27. Manner of Death 1 □Natural 5 □ Pendin	28a. Date (Moi	of Injury oth, Day Year)	28b. Time of Injury		yury at Vork?		28d. Describe how	injury occi	urred	
oath. Dr: A	Certification:	2 Accident investig	ation 4/11/	04 found	found 8	3:30a	☐ Yes 2 🗶 i	No	unknown			
rect by t	tific	3 ☐ Suicide 6 🗷 Could (4 ☐ Homicide determ	and 289. Plac	e of Injury - At hor ling, etc. (Specify	me, farm, str	eet, factory, offi	Э	1	 Location (Streetly or Town, 	et and Nun State)	nber or Aur	al Route Number,
rs af	Cer		found	in harse				ļ	2502 M:Her	ry St.	, Balt	imore, Md
within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director. It	ical	(Check only Medical	g Physicien: To th Exeminer: On the l	pasis of examinat								
the I	Medical	one) 2111	and mai	nner stated.								
Lon Con	2	29b. Signature and title of certifie	- W	,	h 2 -		ense number					Day, Year)
		Tusha	1/Iree	herz	NIR	0.0	.M.E.		F	pril	12, 2	2004
		30. Name and address of person	who completed cau	se of death (Item	23а) (Туре,	Print)			1 # 2	Max-1	land o	1201
		Tasha ZGI	reenber	M MD		1 Penn	Street	, ва.	Ltimore,	MdI.Y.	ralia 7	
Sta		31. Date filed (Month, Day, Year)		Régistrar's Signat								
Registr	ar	AF	R 2 0 200	4 Sien	المر ويمان	1 Jane	Mr. a					
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Chneeberger 100 A erNice 04 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) BALTIMORE laris tella limonium If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours 1□M 200F 212-22-739 Yrs. Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b Count 10a State 1 Yes 2 No BALTIMORE ARK VILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) uaa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) daughte ckville mD Carriage -arm a 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem! 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PALTIMORE, MD EVANS FUNERAL CHAPEL RENTOLK M Approximate Interval Between Onset and Death complications that caused the only one cause on each line. 23a. Part1. Enter the disease, of shock, or heart fallure. List death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) CARDIOVASCULAR DISEASE Due to (or as a consequence of): ARTERIOSCLEROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that introduced to the control of Due to (or as a consequence of): consequence of): 23d. Date of delivery

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

ir than "natural", or items 23a or 28a-f shot the Medical Examinat must be notified at

other than

traumatic

Important: If item 27 is m any injury or other trauma

90 and Mental

permit. Pages 1 and 2 should I Department of Health and Ment

Maryland 21215-0036

Baltimore,

P.O. Box 68760

Division of Vital Records,

or Attending Physician:

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Completed by Funeral Director

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certificate has

After this

death.

To the Hospital or within 24 hours at To the Funeral D

after death the

filled in by

Medical

State

Registrar

29a. Certifier

Examiner Physician/Medicai þ Be Completed 25. Certification: To 27.

that initiated events resulting in death) Last	Due to (or as a
IF FEMALE: 23b. Was decedent pregnant in the past 12₁months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 1 9 ☐ Unknown

. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 4□ Pregnant at time of death 9□ Unknown	3 ☐Ectopic pre- 5 ☐ Other (spe-

gnancy cify)

Dav Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Unknown

autopsy performed? 2 √ No 1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Was case referred to medical			26. Place	of Death (Che	ock only one)	
examiner? 1 ☐ Yes 2 🗗 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3□ DOA Other: 4 V Nu	ursing Home	5 Residence	6 □Other (Specify)
Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at		Describe how inju	

1 X Natural 5 Pending 2 Accident investigation 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

21093

(Check only one) and manner stated title of certifier 29b. Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

TIMONIUM

29c. License number

29d. Date signed (Month, Day, Year) 4-16-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDDIE NAKHUDA, 2300 DULANEY VALLEY ROAD

32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 2 0 2004

State of Maryland / Department of Health and Mental Hygiene

			State	on Ivianyland / D	Certificate of L	eaim and Memarry Death	Reg. No.	12003
	Dharaisi		1. Decedent's Name (First, Middle, Last)	0 :11	1	2. Dete of Do		3. Time of Death
	Physici /Medio		Valerie G.	Smith	h	Horil	16 2004	11:00PM.
المريا	Examir		4a Fecility Neme (If not institution, give street and no	umber)	4	b. City, Town, or Location of Deet	0	
			5. Social Security Number 6. Sex	7. Age (In yrs. lest birth	hday) If Under 1 Year	TUnder 24 Hrs. 8. Date of Bi Hours Min. (Month, Di	th DACTI	hplace (State or Foreign
П	Funeral Director		212-01,9423 10M 2/F		rs. Months Days	Hours Min. (Month, Di	ey, Year) Co	EYLAND.
		•	Usuel Residence of Decedent	10c. City, Town	or Location			10d. Inside City Limits
	shov	7	10a. Stete 10b. County	Toc. Oity, Town		_		1 12 Yes 2 □ No
	28a-1	Director	10e. Street end Number		SALTIMOR 10f. Zip Code		10g. Citizen of What Co	untry?
	3a or	2	1920 Donachie Rd. F	LO+ 501	6	21239	USA	
	deat	Funerai	11. Meritel Status 12. Was De	cedent Ever in U,S.	13. Was Decedent of Hi If Yes, specify Cuba	spenic Origin? (Specify Yes or No., Mexican, Puerto Rican, etc.)	0- 14. Race - Amer Black, White	
20	hours efter death with the Marylend turel', or frems 23a or 28a-f show al Examiner must be notified at	by Fu	1 Never Married 2 Married 1 Yes, G 3 Widowed 4 Divorced Yeer or	200 No	1□ Yes 2 No	Specify:	Specify: 11	hite.
21215-0020	naturel'.	8	15. Decedent's Education	16e. l	Decedent's Usuel Occupe	ition	16b. Kind of Business/	Industry
215	within 72 ena. than "nat	Completed	(Specify only highest grede completed	(1-4or 5+)	(Give kind of work done of life. DO NOT use retired	furing most of working		
7		S	7		am otress	<u> </u>	M:4-2	
and	I be filed ntal Hyg ed other event,	Be	17. Fether's Nerhe (First, Middle, Last)	100000		18. Mother's Name (First, Middle	, Maiden Surname)	
Maryland	should ad Me merk metic	ဥ	19a. Informant's Name/Relationship (Type, Print)	demore 196.	Mailing Address (Street a	and Number or Rurel Route Numb	per, City or Town, State, 2	ip Code) 7.12.39
	and 2 saith er n 27 is		Dolores Earhard			hie Rd, Apt 50		RE MO
ore,	ーエッチ		20a. Method of Disposition	20h Place of	Disposition (Name of cramatory or other place	_) Date	20c. Location - City or	
<u>Ë</u>	Ø ÷ = 0		1 ☐ Burial 2 DC Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	EVANS F	FUNERALCH	apec- 4-17-04	Forest Hi	II, MD
Baltimore,	Demit. Peg Dapartment Important: I any Injury o		21. Signature of Funeral Service Licensee		22. Name and Addres	s of Facility BALTIMO	2E, MO 212	.34.
_	00 = 6 a		Himberly a. Zan	otry	EVANS FUL	SERAL CHAPEL	8880 HARRE	epep.
-		8	23a. Part1. Enter the disease, or complications thet shock, or heart failure. List only one cause on	ceused the fleeth. Do no eech line.	ot enter the mode of dying	g, such as cardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final	1. In to	1.		1	
	Examiner		disease or condition resulting in death) e/	Due to (or es e c	consequence of):		1	
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	* O 6	edical	resulting in death) Last	Due to (or as a co	onsequence or).		1	
Вох	aath cart attendin I for usa	Physician/N	d					
	e daa the att	/sici	Part II. Other significant conditions contributing to	death but not resulting in	the underlying cause give	on in Pert I. 23b. Dld	tobacco use contribute	
P.0	that the danged by the and datached for					1	Yes 2□No 3□Pr	robably 4 thknown
of Vital Records,	8 50	d by						Were autopsy findings
000		Completed				perf		available prior to completion of cause of death?
æ	The law ata has t page 2 s	E O				10	Yes 2 4th 1	1□Yes 2□No
ital		Be C	25. Was cese referred to medical examiner?			26. Plece of Death (Check only	one)	
7	Physician: this cartific ral diractor,	2	1 Yes 2	Inpatient 2 ER/Out		4 Mursing Home 5 ☐ Hes		sify)
	الم الم	Ö	investigation	e of Injury onth, Dey Year) 28b. Ti	njury Work	at 28d. Describe ?? /es 2 □ No	how injury occurred	
Division	Attending or death.	fical	3 Suicide 6 Could not be determined 28e. Plec	ce of Injury - At home, far		28f. Location	(Street and Number or Ru	ural Route Number,
5	s after a Dire	Certification:	4 Homicide buil	ding, etc. (Specify)		City or 10	iwn, State)	
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A complataly filled in by the fo	edicai (29a. Certifier (Check only 2 Medical Examiner: On the	e best of my knowledge, basis of examination end	death occurred at the time	e, date end plece, and due to the pinion, death occurred et the time,	ceuse(s) and manner as date and place, and due	stated. to the cause(s)
	To the H within 24 To the F complate	Medi	one) and me	nner steted.	29c. License	number	29d. Date signed (Montl	h. Dav. Year)
	So Weigh		29b. Signature end title of certifier	· / n.	0 1400	54424	(1 1/ - 2	mel
	1		30. Neme end eddress of person who completed cer	use of deeth (Item 23e) (Type, Print)		4-16-2	W7.
	J		Drus Asadi 20 E	Timoniu	mrd. Tir	54424 nonium, MD	21093 5	uite 209
	Sta Registi			Registrer's Signeture	Accept 8			

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20014 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Henry **Physician** S aund ers 04:35 AM 2004 April 18 L eroy -/Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Saltimore N/AIf Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min Days Hours 1 M 2 □ F Yrs Director 07-26-1931 MARYLAND 217-34-2994 Usual Residence of Deceden death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "naturel", or items 23e or 28a-f show other traumatic event, IV.e M-Jical Examiner must be notified at ty Yes 2 □ No N/A BALTIMORE Director MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 4102 GARRISON BLVD 21215 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1√7 Yes 2 No IFYes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2□ No Baltimore, Maryland 21215-0036 Specify. ģ 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then eny injury or other traumatic event, If we Man Elementary/Secondary (0-12) College (1-4or 5+) REMAN CONSTRUCTION

18. Mother's Name (First, Middle, Maiden Sumame) ENGINEER-FOREMAN 12 17. Father's Name (First, Middle, Last) Be CHARLES SAUNDERS MARTHA GROSS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4102 GARRISON BLVD, BALTIMORE, MD 21215 ace of Disposition (Name of Date 20c. Location - City or Town, State LENORA SAUNDERS, DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State 04-30-04 garrison Forest MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21. Signature of Funeral Service Licenses 6 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BALTO, MD Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration week. Treumonia Pnysician disease or condition resulting in death) /Medical to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1 Yes the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death | Check on v one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes '3 No 2 this 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie April 18. 2004 your M.D.

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 N. Greene

T. Jones, M.D.

Jeffrey Gordon Sanford Jnknown 04-115 04-02358

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene \(\Omega\) \(\Omega\) \(\Omega\)

m		·	1 - State Registrar				Certific	ate of	Death		Reg. No		12005
П	Physici	an		ne (First, Middle, La						2. Date of D Month	eath Da	y Year	3. Time of Death
	/Medic		Jeffrey	Gordon	Sanford					April	06	2004	5:55 A M
7	Examir		4a. Facility Name ('If not institution, giv	e street and number)		4b. 0	ity, Town, o	r Location of Deat	h	40	. County of Deat	h
				Paul Stre				Baltim				N/A	
	Funeral		5. Social Security N		lex 7. Ag 1X M 2 ☐ F	e (In yrs. last bir.	Mon	hs Days	If Under 24 Hrs Hours Min.	(Month, L	irth ay, Year)	9. Birt	hplece (State or Foreign untry)
	Director		215-74-311	<u>ي</u>	A	41	Yrs.			NOV 19	, 1962	2 New	York
	and w		Usual Residence of 10a. State	10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Aaryli sho	ō	Maryland	Anne Arund	<u>اط</u>	Glen B	mie						1 Yes 2 TNo
	28a-	ect	10e. Street and Nu		A.J.	GIGIE		Zip Code			10g Ci	tizen of What Co	untry?
	with a or	Funeral Director	303 Fernda					21061			USA		
	eath rs 23	era	11. Marital Status	de mara	12. Was Decedent	Ever in U.S.			lispanic Origin? (S	pecify Yes or N	<u> </u>	14. Race - Ame	rican Indian.
	ter d	5		ried 2 Married	Armed Forces?		If Yes,	specify Cub	lispanic Origin? (S an, Mexican, Puerl	o Rican, etc.)		Black, White	
336	urs af	by	3 ☐ Widowed		If Yes, Give Year or Dates:		1 🗆 Ye	s 2XNo	Specify:			Specity:	White
21215-0036	within 72 hours after death with the Maryland ane. than "neturel", or items 23e or 28e-1 show ite Medical Exercite round by position at	Completed		15. Decedent's Ed		16a.	Decedent's	Jsual Occup	pation		16b. K	ind of Business/	Industry
215	hin 7 In "n Med	ple	Elementary/Sec	cify only highest gra	College (1-4or	5+)	life. DO NO	T use retire	during most of wo d)	rking			
21	d with giene.	оп По	2.00	., (5 12)	2	La	aborer				Co	nstructi	on
	e filed al Hygi l other vent, I	Be (17. Father's Name	(First, Middle, Last,)				18. Mother's Nar	me (First, Middi	e, Maider	Sumame)	
<u> a</u>	should be find Mental to marked of umatic even	Tof	Harry	7 F. S	anford				Carol	e Lee	Ge	ng	
Maryland	2 sho and l	1 8		lame/Relationship (les .			and Number or Ru		ber, City o	or Town, State, 2	(ip Code)
	1 and 2 Health tem 27 is		Constanc	e J. Sto	tsky/Grand				sey Aven		Gle	n Burnie	e, MD 21060
ore	of He of He roth	. "	20a. Method of Dis		Removal from State	20b. Place of cemeter	Disposition y, crematory	Name of or other plac	CB)	Date	20c. L	ocation - City or	Town, State
Ĕ	Peges nent of I snt: If its ury or o			5 ☐ Other (Specif		Metro	Crema	tory I	nc. 4-1	7-04	Ва	ltimore,	MD
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28a-1 show any righty or other traumatic event, the Marinal Examilies much by notified at Once.		21. Signature of F	uneral Service Liee	1300	A CONTRACTOR OF THE PARTY OF TH	22 Nam Crei	and Addre	ss of Facility Society	of MD.	Inc		
<u>—</u>	89E # 9		Edv		egorchik		299	Frede	rick Roa	d Bal	timo	re, MD	21228
*			23a. Part1. Enter shock, or hea	the disease, or com art failure. List only	plications that caused one cause on each li	d the death. Do r	not enter the	mode of dyin	ng, such as cardia	or respiratory	arrest,		Approximate Interval Between
6	Physician		Immediate Cause disease or condition	(Final	Sout	inhala	rtion	and.	thermal	injuri	23		Onset and Death
-	/Medical		resulting in death)		Due to (or as	a consequence	of):			J			
	Examiner		Sequentially list co	onditions	b								
	D #	Examiner	if any, leading to it cause. Enter Und	mmediate erlying	Due to (or as	a consequence	ວົາ):					Í	
	nd rrans	am	Cause (Disease or that initiated event resulting in death)	r injury	c.								
Ő,	tificate be executed ig physicien and as the burial-transit		resulting in Ceath)	Last	Due to (or as	a consequence	of):					- 4	
68760,	ate b hysic the b	Aedicai			d								
_	ing p	Med	IF FEMALE:								°		
Box	ath co	lan/	23b. Was deceder in the past 12			2 Fetel death		c pregnancy	1			23d. Date of deli Month	very Day Year
	the a	Physiclan/A	1 ☐ Yes 2 9 ☐ Unknown	□No	4□Pregnant a 9□ Unknown	t time of death	5 Other	(specify)			1		,
P.O.	The law requires that the death certificate be executed to has been signed by the attending physicien and cage 2 should be detached for use as the burial-transit	H)			contributing to death b	out not reculting in	the underlyi	an called an	an in Part I	23e Did	tobaccou	use contribute to	the cause of death?
ţs,	signe d be c	by		Chronic	alcoholi	-	i tilo ulicolly	ig cause giv	WINT OUT.		Yes 2		1/
0	w requir been si should	etec		37170								· · · · · · · · · · · · · · · · · · ·	
Records,	e 2 s	Completed									opsy	24b. Were au prior to d	topsy findings available completion of cause of
F		Col									formed? 2 \(\subseteq No	death?	2 🗆 No
of Vital	Physician: The laviths certificate has	Be	25. Was case refe examiner?		Hospital:			Oth	26. Place of Dea			V	at ggono
of	Phys this al dir	To	1 X Yes 2 27. Manner of Dea	1140	i □ inpatie		tpatient 3	DUA	4 🗆 Nuising F			6 Dether (Spec	at scene
- LC	ter ter	lon	1 Natural	5 Pending	28a. Date of Inju (Month, Da	v Yearl	Time of njury at Work? d 52 So/tM 1 1 Yes 2 10 No Un K r				njury occurred Chowh		
isi	r Attending er death. rector: After by the fune	icat	2 Accident 3 Suicide	investigation 6 Could not b	e 20a Place of loi	ury - At home, fa	d 52 SOAM	-	193 2 IA(NO				ral Route Nymber,
Division	of or Attendir after death. Director: Af d in by the fu	ertification;	4 Homicide	* determined	building, et	c. (Specify)		oar K		City or To	own, State	300 5	t paul st

To the Hospitel or A within 24 hours after or To the Funeral Director Completely filled in by

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29a. Certifier

29c. License number O.C.M.E.

a park

29d. Date signed (Month, Day, Year) April 06, 2004

mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ling Li, M.D.
31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

32. Registrar's Signature

			1 - State Registrar	State of Marylar	_		of Healt of Dea			Reg. No. UU4	12006
	Physici	an	1. Decedent's Name (First, Middle, Last) Carolyn Leatrice S	erio					2. Date of Dea Month April	Day Yeer	3. Time of Death 7:45a.M.
>	/Medic Examin	_	4a. Facility Name (If not institution, give st			4b. City,	Town, or Locat	ion of Death	APILI	4c. County of De	
			Lookabout Manor				ninster			Carrol	
	Funeral Director		213 30 3303	7. Age (In yrs. 72	last birthday) Yrs.	If Under Months	1 Year If Ur Days Hou	nder 24 Hrs. Irs Min. Sept	8. Date of Birt (Month, Da ember 1	9. B 9. Year) 8, 1931 Ma	irthplace (State or Foreign Country) aryland
	puq		Usual Residence of Decedent 10a, State 10b, County	10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or liems 23a or 28a-f show that the Medical Evant her must be notified at	ō	Maryland Carroll		ersbur						1 ☐ Yes 2 No
	28a-	rect	10e. Street and Number			10f. Zip	Code		T	10g. Citizen of What C	Country?
	3a ol	D E	2023 Rudy Serra Dr	ive Apt.2D		2	21784			United S	tates
	death	Funeral Director		Was Decedent Ever in U Armed Forces?	.S. 13.	Was Deced	ent of Hispanic	Origin? (Species Puerto	ecify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh	nerican Indian,
စ္	or its		1 Never Married 2 Married	1 ∐ Yes 2 Ž∭No ff Yes, Give		1 ☐ Yes 2			, , , , , ,	Specify: V	
ğ	hours	ed by	3 Widowed 4 □ Divorced 15. Decedent's Education	Year or Dates:	16a Dagg	dont's Lieus	Occupation		1	16b. Kind of Busines	
ŗ	in 72	olete	(Specify only highest grade	completed)	(Give	kind of wor DO NOT us	k done during i	most of work	ing	160. Kind of Busines	windustry
21215-0036	with jiene.	Completed	Efementary/Secondary (0-12)	Colfege (1-4or 5+)	Clerk					Federal Go	verment
פ	il Hygir other	Be C	17. Father's Name (First, Middle, Last)				18. M	lother's Name	e (First, Middle,	Maiden Sumame)	
Maryland	should be ind Mental marked o	To E	Nathan Smith				Do	ra Lev	7in		
a	2 sho and I is ma		19a. Informant's Name/Relationship (Type	e, Print)						r, City or Town, State,	10.0
-	s 1 and of Health item 27 other tr		Mrs. Cynthia Bentz	205					minster,	Md. 21157	
Ö			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	Place of Dispo cemetery, crer	natory or ot	her place) Garden	I		20c. Location - City of Finksburg,	
Baltimore,	permit. Pag Department Importent: I any injury o		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licensee							0 -	
Ba	Depa Impo any i		Most Bullet		8	728 L:	iberty	Road,	ring Bye Randall	ers Funeral stown,MD.	Directors,I 21133-4784
3/60,	death certificate be executed e attending physician and ider use as the burial-transit	Ilcal Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consecutive to (or a))).	juance of).					yvy	
O. Box 6		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pregni 1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown	ıl death 3 ☐	Ectopic pre				23d. Date of do Month	elivery Day Year
ds, P	ires tha signed d be de	by	Part II. Other significant conditions cont	ributing to death but not res	sulting in the u	nderlying ca	iuse given in P	art I.		bacco use contribute 'es 2 □ No 3 □ F	to the cause of death?
Record	The ate h page	Completed				· · · · · ·			24a. Was autop perfor 1 Yes	sy prior to	autopsy findings available completion of cause of
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?						(Check only o		149 ISTED
0	Physic this c	2	1 □ Yes 2 No		ER/Outpatier		A Other: 4			ence 6 Other (Sp.	acity) This willow
u C	ing After une	lon	27. Manner of Ceath Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M	3c. Injury at Work? 1 ☐ Yes 2		280. Describe n	ow injust occurred	
Division	r Attenter deat irector:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special			_	_	28f. Location (S City or Tow	itreet and Number or F n, State)	lural Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical (29a. Certifier (Check only one)	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death	n occurred a vestigation,	at the time, date in my opinion,	e and place, death occurr	and due to the ded at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	2		29c.	License numb	oer		29d. Date signed (Mor	ith Day, Year)
			Morough	D. D. 8).		1	1003	558	45	4/15/	2004
	1		30. Name and address of person who con	npleted cause of death (Iter	n 23a) (Type,	Print)	/ /.	2 -		-1 /1	7
	10		KEUIN BREWST	ER, 688	POOLE	-/	x, 1	159/1	1/105/8	ER, 194.	2/157
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 0 2	32. Registrar's Signa	ature 14	Local	6.8				

State of Maryland / Department of Health and Mental Hygiene 2 0 0 [Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2004 Spencer April P^{M} 7:24 /Medical 4a. Facility Neme (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3700 Greenspring Avenue, Apartment 715 Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)
MANYLand **Funeral** 1 M 2 F Days Hours Min Year 220-64-242 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be natified at Baltimore 1 THES 2 □ No Ma Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? or items 23a or 3700 GREENSPRING 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No BLack Specify: Specify: Completed by 3 Widowed 4 Divorced "natural". 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DISAble permit. Pages 1 and 2 should be filled. Department of Health and Mental Primportant: if them 27 is meany injury or other. other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Spencer EdWARD MARTHA GROSE 2 19a. Informant's Name/Relationship (Type, Print) in The 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 814 N. Colling ton Arre Balto . ind. Meresia Spencer 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 25 hele 21. Signature of Fun-ral / ervice Livensee 23d. Part1. Enver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. hyperthsive cardiov **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is intended.) Due to (or as a consequence of): Examiner Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No Yes 2 No 25. Was case referred to medical examiner?

∑Yes 2 □ No 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Nother (Specify) at SCENE Hospital: 2 .cal or Au.
.ours after death.
.al Director: After u
.by the tuneral director. 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 TYes 2 □ No 2 Accident 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Sign and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 02, 2004 39: Name and address of person who completed cause of death 111 Penn Street, Baltimore, Maryland 21201 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 2 0 2004

DHMH 17 Rev 1/2001

ORIGINAL

			1 - State Registrar	State of Maryland	d / Department of Certificate of		ental Hygie	2004	12008
ĺ	Physicia		1. Decedent's Name (First, Middle, Last) Albert E.	5 mith, J	\mathcal{R} .		2. Date of Death	Day Year	3. Time of Death 8'07 AM
A.	/Medic Examin Funeral		4a. Facility Name (If not institution, give s 6004 Sam 5. Social Security Number 6. Sex	enitan 14	bsp. BAL	n, or Location of Death I MORE Bar If Under 24 Hrs. ys Hours Min.	8. Date of Birth (Month, Day, Ye	4c. County of Death 9. Birth	place (State or Foreign
	Director	1	Usual Residence of Decedent 10a. State 10b. County		y, Town or Location		12-30-	3111/14	10d. Inside City Limits 1 Yes 2 No
	death with the Maryland ms 23e or 28e-f show r must be notified at	Director	10e. Street and Number	MORE 1	PARKVIL 10f. Zip Cod	LE	10g.	Citizen of What Cou	
20		by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Amped Forces? 1 DXYes 2 No ff Yes, Give Year or Dates:	.S. 13. Was Decedent If Yes, specify 0	of Hispanic Origin? (Specuban, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Ameri Black, White	
00-6171	be filed within 72 hours after tal Hygiene. Id other then "natural", or Ite event, It e Medical Exemine	Completed t	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	eation	16a. Decedent's Usual Oc (Give kind of work do life. DO NOT use re	ccupation one during most of working tired)	g 16b	. Kind of Business/Ir	ndustry = Cit+4
ylanu z	should be filed ind Mental Hygis marked other umatic event, III	To Be Co	17. Father's Name (First, Middle, Last) Albert & Smi	th, Sr.		18. Mother's Name	sa M.	Akers	E 0119.
e, mar	1 and 2 sho Health and em 27 is m		19a. Informant's Name/Relationship (Ty, 20a. Method of Disposition	ith-wife.	19b. Mailing Address (Str	tin Ave, F	ARKVILL	ity or Town, State, Zi	21234.
altimor	t. Page ntment o ntent: tf njury or		1 ABurial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	emoval from State	kuund lo matery or other	place)	04 P	HEKULLE	mD
Ď	Departing Department of the policy of the po	K N	23a. Part1: Enter the disease, or complishock, or heart failure. List only or	cations hat caused the death e dause on each line.	EVANS FL	NERALCHA	PEL-882	OHARFOR	
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	ROSCLERO uence of):	TIC COR	DISEA	VASCU-	EALS
, c	eath certificate be executed attending physician and for use as the buriat-transit	dlcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a consequence					
O. BOX BB	at the death certificate by the attending phys nached for use as the	Physician/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	Il death 3 □Ectopic pregna			23d. Date of deliv	rery Day Year
cords, P.	w requires that is been signed by should be deta	þ	Part II. Other significant conditions cor	tributing to death but not resu	ulting in the underlying cause	given in Part I.	23e. Did tobac	co use contribute to to 2 No 3 Pro	the cause of death?
al Keco	The law ate has b page 2 si	Completed					24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
OT VII	Phys this al dii	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 Inpatient 2 I	28b. Time of frigury 28c. I		(Check only one) ie 5 Residence 8d. Describe how i		(v) Good Sumari Han Hospital
Division	To the Hospitel or Attending Pt within 24 hours after death. To the Funerel Director: After it completely filled in by the funeral	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, factory, off	ice 2	8f. Location (Stree City or Town, S	t and Number or Run tate)	al Route Number,
	To the Hospitel or within 24 hours after To the Funerel Director Completely filled in E	Medical	(Check only 2 Medical Exami	ner: On the best of my kno- ner: On the basis of examinal and manner stated.	ttion and/or investigation, in n	ny opinion, death occurre	d at the time, date	and place, and due t	to the cause(s)
•	o 1 1 1 1	-	29b. Signature and title of certifier	Mon	7.	0 0 4 76 a	35	Date signed (Month, 4/19/6)	4
	1		30. Name and address of person who co	malley,	n 23a) (Type, Print) MD 1600	OSLERD,	RIVE, ST	TE 311, TO	DWSON
	Sta Registi		31. Date filed (Month, Day, Year) APR 2 0 20	32. Registrar's Signa	he A wa	W		M	14164

			For State	State of Ma	ryland /		rtment of H tificate of l			-	.004	12009
		4	Registrar 1. Decedent's Name (First, Middle, La	st)			imouto or t	Journ	2. Date of De			3. Time of Death
F	hysicia		Yamar	1.	S	ingh			April	1 3	2004	11:02 pm
	/Medic Examin		4a. Facility Name (If not institution, giv			, c. r.g. r		Location of Death	110.000		County of Deat	
			Laurel Region	al Hospita	l		Law				Prince	
	uneral rector		5. Social Security Number 6. S 220-37-4691	C	(In yrs. last b	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Feb. 15	ıy, Year)	9. Birtl Co 3 Pak	hplace (State or Foreign untry) いまたan
aryland	show	20	Usual Residence of Decedent 10a. State 10b. County		10c. City, To		eation					10d. Inside City Limits 11/□ Yes 2 □ No
he M	28a-f	Director	MD Prince 10e. Street and Number	George	Lau	rel	10f. Zip Code			10a Citi	zen of What Co	
with	Lean	급	5716 Huckburn Cou	u +			20707			rog. On.		
death	ms 22	Funerai	11. Marital Status	12. Was Decedent Ex	ver in U.S.	13. V		spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No)-	Indi 14. Race - Ame	rican Indian,
d 6.16.10-0000 filed within 72 hours after death with the Maryland Hygiene.	item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			Yes, specify Cuba	n, мехісап, Риепо Specify:	Hican, etc.)		Canalha	sian ndian
72 ho	alcal I	eted	15. Decedent's E (Specify only highest gra	ducation	16	(Give I	ent's Usual Occupa	during most of work	ing	16b. Kir	nd of Business/	Industry
d within jiene.	ina Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+ 3+		Owne	OO NOT use retired)		00	wn Busi	ness
al Hy	othe	Be (17. Father's Name (First, Middle, Last					18. Mother's Nam		, Maiden	Sumame)	
y and y ould b	arke atic	2	Laxman Singh		1			Vttam D				
12 sh h and	7 is m traum		19a. Informant's Name/Relationship (Jasbir Singh / So					and Number or Run		-		
ss 1 and of Healt	item 2		20a. Method of Disposition 1 Burial 2 Cremation 3		20b. Place	of Dispos	sition (Name of natory or other place	e)	Date	20c. Lo	cation - City or	Town, State
partification of the property of the permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene.	rtant: H njury o		*4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice	y)	Balt/		Cremator	s of Facility F.			rel, Ma	-
perm Depa	eny ir		21. Signature of Contents Service Co	M	61350							land 20707
4			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused tone cause on each line	the death. Do	o not ente	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
333	sician edical		Immediate Cause (Final disease or condition resulting in death)	a. BILATE Due to (or as a			NEUM	OMIA				Onset and Death WEEK
	miner		Sequentially list conditions,	b	,							
petn	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequenc	e of):						
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ficate	phys s the	edicai		d								
UIVISION OF VICE THE COLORS, F.O. BOX of To the Hospital or Attending Physician: The law requires that the death certifulning 24 hours after death.	been signed by the attending p should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Petal dea		Ectopic pregnancy Other (specify)			2	23d. Date of deli Month	very Day Year
us, r.	signed by d be deta	by	Part II. Other significant conditions	contributing to death but	t not resulting	in the un	derlying cause give	en in Part I.		obacco u Yes 2[the cause of death?
e law requires t	has been si e 2 should	Completed							24a. Was		24b. Were au prior to death?	topsy findings available completion of cause of
Hall F	icate r, pag								1 ☐ Yes	2. 2 No	1 ☐ Yes	2. No
Sicial	recto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	t 2□ER/0	Outnation	3□ DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho			Other (See	2/5/
ding Phy	ractor: After this certificate has by the funeral director, page 2	-	27. Manner of Death 1. Natural 5 Pending	28a. Date of Injury (Month, Day	/ 28b	. Time of Injury	28c. Injun Worl		28d. Describe			any)
or Attending	Diractor. in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	e 29a Place of Injur		farm, stre			28f. Location (City or To			iral Route Number,
Hospital	To the Funeral Dir completely filled in	edical Ce		nysician: To the best of miner: On the basis of and manner state	examination a							
To the	То the сощрів	Med	29b. Signature and title of certifier	and mariner state	00.		29c. Licenso	3 8			e signed (Month	
(30. Name and address of person who	completed cause of de	ath (Item 23a	i) (Type, I	-			,		
	/_		K. G. BHOJRAJ. 31. Date filed (Month, Day, Year)	17 D - / 0	r's Signatura	RMI	MMMV	77 (1			٠ ، ن	, 5 /
	Sta Registi		30. Name and address of person who R. G. BHO JRAJ. 31. Date filed (Month, Day, Year) APR 2	0 2004	Sugnature	Age.	Godes					

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hysici /Media		Edna T.	Satche1	1				April		204 7:30AM
xamir		1		give street and number,		4b. City, Town,	or Location of Death		4c. County of	of Death
		Sinaj	HOSPI		altimore		TIMORE If Under 24 Hrs.	0 D-1- (D:-	NA	- 5:4
ineral rector		5. Social Security N 217-24-25		1 1 N 2 1 E	ge (In yrs. last birth 76 Yı	Months Days		8. Date of Birt (Month, Day 08-22-	y, Year)	Birthplace (State or Foreign Country) Vincinia
ector		Usual Residence of			70			00.22	1941	Virginia
HOW E		10a. State	10b. County		10c. City, Town	or Location				10d. Inside City Limits
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MET.	Funeral	11. Marital Status		12. Was Decedent Armed Forces	?	 Was Decedent of If Yes, specify Cu 	Hispanic Origin? (Spe ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black	- American Indian, c, White, etc.
ם	by Fu	1 Never Marr 3 Widowed	_	If Yes, Give	No	1 ☐ Yes 2 TNo	Specify:		Specify:	D1 1-
al E		2 MANGOMEG	15. Decedent's	Year or Dates:	162 [ecedent's Usual Occi	upation		16b. Kind of Bus	Black siness/Industry
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event, the Me	Be C	17. Father's Name	(First, Middle, L	.ast)			18. Mother's Name	e (First, Middle,	Maiden Sumame	9)
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othar traumati		19a. Informant's N	ame/Relationsh	ip (Type, Print)			et and Number or Rura			
ar tre		Yvonne E	. West/	Daughter					Columbia	, MD 21044
r othar tr	111	20a. Method of Dis	•	3 □Removal from State	cemetery	isposition (Name of crematory or other pl		Date	20c. Location - (City or Town, State
ury o						cramatory or other pr	ace)			
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Funeral Diractor: After this certificate has been signed by the attending physician and 10,000. Important: If it is earlificated the specification of the funeral director, page 2 should be detached for use as the burial-transit 10,000. Que.	o Be Completed by Physician/Medical Ex	23a. Sant 1. Enter the state of	onditions, nmediate errying injury stast at pregnant months? No Pred to medical No the disease, or or or failure. List or (Final on onditions, nmediate errying injury stast	b. Due to (or a: Complications that cause only one cause on each	Woodlaw I de the death. Do no line. I C C I C C I S a consequence of I S a conseque	n Cemetery 22. Name and Addi Wylie Fun t enter the mode of dy Cer : 3 □ Ectopic pregnan 5 □ Other (specify) the underlying cause go astient 3□ DOA The of 28c. Injury	ress of Facility neral Home ying, such as cardiac of given in Part I. 26. Place of Deatt Other: 4 Nursing Ho ury at ork? Yes 2 No	23e. Did to 1 N 24a. Was autop perfo 1 Yes h (Check only o	23d. Date Mon bbacco use contri (es 2 \(\text{No} \) an 24b. W py med 22 \(\text{No} \) dence 6 \(\text{Other} \) thence injury occurre Street and Number	Approximate Interval Between Onset and Death Z Year S of delivery th Day Year bute to the cause of death? 3 Probably 4 Dunknown / Gree autopsy findings available rior to completion of cause of path? Yes Wo

State Registrar

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHIA PORTERA; MD. Singli Hospital of Baltimore, 24ol W Belvedere Ave.

31. Date filed (Month, Day, Year)

APR 20 2001

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Doris Lorraine Schalis 2004 1040 AW. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Stella Maris @ Mercy Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 ☐ M 2 🛭 F 219-40-7623 85 8-4-1918 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1⊠Yes 2□No MD n/a Baltimore Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 3802 Bank Street 21224 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 █XNo If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White Be Completed by 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) In own Home Home maker 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henry Hildebrand Mary Koehler 19a. Informant's Name/Relationship (Type, Print) daughter19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Judith A. Kendzejeski 1918 Quentin Road, Baltimore, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 4/20/04 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Joseph N. Zannino Jr.FH 21. Signature of Funeral Service Licensee 263 S. Conkling St., Baltimore, MD 21224 exvere 23a. Part1. Enter the disease, or o she lications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death congestive head fully Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Due to (or as a consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 1 ☐ Unknown Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Norther 10 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Deeth Medical Certification: Injury 1 Natural 5 Pending 2 🗆 No 1 Tyes investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide

Division of Vital Records, P.O. Box 68760; To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours effer death.

To the Funeral Director: After this certificate hes been signed by the attending physicial completely filled in by the funeral director, page 2 should be deteched for use as the hurstone.

Funeral

Director

permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryle Depertment of Health and Mentel hygiene. Important: If Item 27 is marked other than "natural," or items 23a or 28a-f shon any injury or other traumatic event, the Medical Exacuter must be not titled at

Physician

/Medical Examiner

Baltimore,

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only

32. Registrar's Signature

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

3

1 - Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

4/19/2004 301 ST. PAUL PL BALTIMORE 21202

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 14:15 THOMAS 2004 C14 ADV 1 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard Howard County General Hospital Columbia If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Months Ohio Aug 13, 89 Director 212-30-6710 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County in than "natural", or Items 23a or 28a-f show 1 ☐ Yes ANNO Elkridge Howard Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21075 U.S.A. 8008 Riker Road Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygenen.

wit: Hitem 27 is marked other than "ratural", or Items 23 in the firem traumatic event, in a Madical Examination or other traumatic event, in a Madical Examination must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Carmella Novell Dominic Liberatto ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 114 Idlewilde Road, Severna Park, Maryland 21146 Mr. James L. Scott / grandson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State April 20 2004 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department Important: It any injury or once. Maryland Veterans Crownsville, MD ⁴ □ Donation 5 □ Other (Specify) 21. Signature of Fundal Service Licensee 22. Name and Address of Facility Singleton Funeral Home P.A. 1 Second Avenue S.W., Glen Burnie, MD 21061 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Exsangumation
Due to (or as Ponsequence of): Minutes /Medical Examiner temorrhagic minutes Shock Sequentially list conditions, if any, leading to immediate cause. Erries Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons sence of) Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical as the Records, P.O. Box 687 attending | IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) I□Yes 2□No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Dolmonary hypertension, Tricusped regurgitation 1 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? diserse 24a. Was an reactive alvways page 2 autopsy performed atrial fibral latin = rapid ventral extremes on marterial Yes 2 vio 1 Yes 2 H certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 es 2 No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred patient climbed out of bed + pulled out Ovinton + Picciones After Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 TM6 death. April 14/04 ~ IP in by the Director: Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Howard Cumby 6 ☐ Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 Homicide 5155 Cedar Lane, 21044 Columbia 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D314 NE 14,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210-12 PATRICE HEMLOCK CONE WAY ELLICOT CITY MO 4565 31. Date filed (Month, Day, Year) 32. Registraris Signature State Registrar APR 2 0 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Ragistra Certificate of Death Rag. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year *Physician 10:47 9M do CAROLYN M. THREET /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner MOY N/A If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number Funeral 1 □ M 2 🖫 F Davs Months Hours MARYLAND 61 Director 220-36-6210 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinar must be notified at MD N/A BALTIMORE 1X Yes 2 □ No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3030 WALBROOK AVE 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married SpeciBLACK ō 1 ☐ Yes 🎗 ☐ No Specify: Completed by 3 Widowed 4 Divorced "netural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. SOCIAL SECURITY Elementary/Secondary (0-12) College (1-4or 5+) CLAIM TECH ADMINSTRATION 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Fisher is marked of should be JAMES BATTY MARGARET EVANS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nt of Health at: if item 27 is 2100 TUCKER LANE C1, BALTIMORE, MD RENEE THREET, DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: if eny injury or once. ARBUTUS MEMORIAL 4 □ Donation 5 □ Other (Specify) 4-21-04 MARYLAND 22. Name and Address of Facility HOWELL FUNERAL HOME 21. Signature of Funedal Service License 4600 LIBERTY HGHTS AVE, BALTO. MD 21207 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician una Canc cons /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injusy that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autopsy 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo P 2 ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

hreet, Carolyn death. after death To the

Maryland 21215-0036

Saltimore,

Medical Certification: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a

To the Fundal C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier D0056092 April ann

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 (aton Avenue Baltmor, Maryland 21229

31. Date filed (Month, Day, Year) APR 2 0 2004

32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

	1	For State Registrar	State of Marylar			nt of H		wentai n	Reg. N		1201
Physician		1. Decedent's Neme (First, Middle, Last)	Van	Ondon			-	2. Date of D Month	D	ay Year	3. Time of Dea
/Medica Examine	ıl r	Katherine Ma 4a. Facility Name (If not institution, give s 1406 Cowsill Drive		Orden		_	Location of Dear	April	18,	2004 c. County of Deel Anne Ar	
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Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28s of show any injury or other treumette event, the Medical Extended in the incultant interest and page.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	kind of v DO NOT	use retired)	uring most of wo	orking	16b.	Kind of Business	
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Departme Important any injury once.	Ī	21. Signifure of Funeral Service License		Do	2. Name ona1o	and Addres	s of Facility Funeral	Home &	Crem	natory, I Marylar	Pennsy:
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within 24 hours after death To the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, fact	ory, office		28f. Location City or 7	(Street own, Sta	and Number or R	ural Route Number,
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		30. Name and address of person who co	ompleted cause of death (Ite	em 23a) (Type	, Print)	D50		D		Paltimor	
Stat	te	Eric Levey, M.D. 31. Date filed (Month, Day, Year) APR 2 0 2004	Kennedy Krie		SLIC	ule /	J NOILI		ay,	Darcino	, FID 21.

		1	State Registrar	State of M	Maryland / Depa	artment of H			Reg. No.	004	12015
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	/Medic	al -	4e. Fecility Name (If not institution, give str		er)	4b. City, Town, or	Location of Death	1 1		ounty of Death	
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ē E	Pages nent of int: If it		KXBurial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	moval from Sta		w Memoria		/16/04	Syke	esville	, Maryland
Baltimore,	permit. Pages i and 2 should Department of Health and Men important: If teem 27 is marke eny injury or other traumatic 2008.		21. Signature of Funeral Service Licensee	report	$\frac{1}{2}$ $\frac{2}{3}$	2. Name and Addres urgee-Hen 631 Falls	ss of Facility SS-Seitz Road B	Funeral	Home Mar	e, Inc. cyland	21211
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Divis	tel or Atters safter des	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of building	Injury - At home, farm, st , etc. (Specify)	reet, factory, office		28f. Location (City or To		Number or Ru	ral Route Number,
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•	With Com	Σ	29b. Signature and title of certifier Charles Uli	u			9987			signed (Month	
	">		30. Name and address of p A n who cor	(D. 3	333 N. CALV	ERT ST.	BALT	O. MD	218	218	
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		-	For State Registrar		State of Ma	aryland		tment of H <i>ificate of</i>	Health and M <i>Death</i>		giene Reg. No.	2004	12016
П			Decedent's Name	e (First, Middle, La	st)					2. Date of De		Year	3. Time of Death
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2	Examin	er	4a. Facility Name (II		street and number)	~		4b. City, Town, o	or Location of Death		4c. C	County of Dea	th N/A
	Funeral		5. Social Security N		ex 7. Ag	Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth						9. Bir	thplace (State or Foreign
	Director		217-37- Usual Residence of	3723	□M 2 7 F	86	Yrs.	Months Days	Hours Min.	DEC. 1	7,191	7	UKRAINE
	e filed within 72 hours after death with the Maryland of Hygiene. of Hygiene. "neturel", or Items 23a or 28e-f ehow vent, ITe Madical Examiter must be mailied at		10a. State	10b. County		10c. City,	Town or Loca						10d. Inside City Limits
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Box 6	death certificate e attending phys d for use as the	√Me	IF FEMALE: 23b. Was deceden	ot pregnant	23c. If yes, outcome						23	3d. Date of de	livery
ğ.	o o	siciai	in the past 12	months?	1☐Live birth 4☐Pregnant a 9☐Unknown			Ectopic pregnanc Other (<i>specify</i>) _	y 			Month	Day Year
0	res that the de signed by the a I be detached f	Phy	9 Unknown		contributing to death b	out not recui	ting in the un	Harlying cause gr	van in Part I	23e Did	tohacco us	e contribute to	the cause of death?
ds,	The law requires that the the has been signed by the has been signed by the hage 2 should be detached.	d by	Colon	concer	Solitibuting to death t	341 1131 1934	iting in the div	aerry ing cause gr	voisini t arti.		Yes 2□		robably 4 Dunknown
Vital Records,	aw require s been sis 2 should b	Completed								24a. Was		24b. Were a	utopsy findings available completion of cause of
Ä.		Com								perfe	ormed? 2 No	death?	2 2 No
/ita	ilcien: Th certificate rector, pag	Be	25. Was case refe examiner?		Hognital:			0	26. Place of Death				
	hye this	- To	1 ☐ Yes 2 ☑ 27. Manner of Dea		Hospital: 1 Inpati		R/Outpatient 28b. Time of	3 DOA	her: 4 🗍 Nursing Hor	ne 5 Resi			ecify)
on	nding P tth. :: After e funera	ation	1 ☑Natural 2 ☐ Accident	5 ☐ Pending investigation	28a. Date of Injuid. (Month, Date)	ay Year)	Injury	28c. Inju Wo M 1	irk?]Yes 2□No				
Division of	in Sir de	Certification:	3 🖺 Suicide 4 🔲 Homicide	6 Could not I determined	286. Place of In	jury - At hor tc. (Specify,	me, farm, stre	et, factory, office			Street and wn, State)	Number or R	ural Route Number,
<u> </u>	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by		29a. Certifier		hysician: To the best								
	the Ho lin 24 I the Fu	ledical	(Check only one)		miner: On the basis of and manner st		on and/or inve			ed at the time,			
	To To	Σ	29b. Signature and	d title of certifier	M			29c. Licen				signed (Moni	
			30. Name and add	tress of person who	completed cause of		23a) (Type. F	(eint)	ZS-000			- 4 - 0	
			Med		in mo		Samoi	Hospil	st of Ben	12mon	e e		
		ate	31. Date filed (Mor	2 0 2004	32. Regist	ar's Signar	by A	oouth					
	Regist	rar	APR	& U 2004		•							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Russell Charles Williams 19, 2004 April 7:20 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Death 4c. County of Death Examiner Manor Care Ruxton Baltimore County Ruxton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 🕅 M 2 🗆 F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** May 19, 84 215-07-9343 1919 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other then "natural; or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√√No Maryland Baltimore Co. Timonium Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Apt. 101 7 Gandson court 21093 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 [X] Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) National Salesman 12 yrs. Baltimore Sun Papers 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Williams Martha Meinhardt 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Ruth H. Williams / Wife 7 Gandson Court Apt. 101 Timonium, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H important: If ita any Injury or of 1 ☐ Burial 2 DCremation 3 ☐ Removal from State Hilltop Service corp. 4/20/2004 4 ☐ Donation 5 ☐ Other (Specify) Towson, MD 21. Signature of Funeral Service Licensee Michael E. Canapp 22. Name and Address of Facility 1050 York Rd. Ruck Towson Funeral Home, INC. Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) Cardial Infarction /Medical Examiner Physician/Medical Examiner To the Noppital or Attanding Physician: The law requires that the death certificate be executed within 20 mours after death.

To the Foreral Director: After this certificate has been signed by the attending physician and completely tilled in by the funeral director, page 2 should be detached for use as the burial-trensit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hunknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 7 M 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 Yes 2 4No 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier H0054424 30. Name and address of person who completed cause of death (Item-23a) (Type, Print) Timonium rd. Suite 209 Timonium, MD 21093 yrus Asadi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:, 20A,M, APRIL Μ. Wederhake 5 2004 Frances /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEI GIEN ARUNDEL BURNIE HOSPITAL NORTH If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 5, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2X F 219-12-5633 MD 79 Oct. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County rthen "naturel", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Funeral Director MD Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21061 USA 230 Maple Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: þ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry . 1 and 2 should be filed within Health and Mental Hygiene. Iem 27 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 3 other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) and 17. Father's Name (First, Middle, Last) Be Lavinia McClain James Randolph Reeves 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Mr. Herman Wederhake, Jr. 230 Maple Avenue, Glen Burnie, Maryland 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Himportant: If Ite on injury or of once. 1 Burial 2 Cremation 3 Removal from State Loudon Park Cemetery Apr. 19,2004 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home P.A. MU13 1 Second Avenue S.W., Glen Eurnie, MD 21061 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) eneborovas cula **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner il any, leading to simile diata cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 fronths? Year Month Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknow signed by t d be detach Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed peeu 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only or Be Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 200No 2 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death
1 Natural
2 Accident 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Division Attending 5 Pending 1 Tes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ö 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Regisfrar's Signature State APR 2 0 Registrar

DHMH 17 Rev 1/2001

EDERA

JA ANG

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 L AMEND ITEM #19b PER FH G833 7/09/04 Certificate of Death 3. Time of Death 2. Date of Death Month 5:45 am Physician APRIL /Medical Location of Deeth Death 4c. County of (If not institution, give street and number) Examiner If Under 1 Year Date of Birth (Month, Day, (State or Foreign 7. Age (by yes. lest birthday) 6. Sex **Funeral** Days Min 1⊿M 2□ F Yrs. Director 10b. County City, Town or Location 10d. Inside City Limits altimore 1 des 2 No Be Completed by Funeral Director 10g. Citizen of What Country? Ever in U,S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Was Deceden Armed Forces 11. Marital Status Black, White, 1 Yes 2 No tf Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced 16a. Decedent's Usuat Occupation
(Give kind of work done during most of working life. Ipo No Juse petition) 15. Decedent's Education (Specify only highest grade completed, drof Business (1-4or 5+) HOMEWOOD PAVERY Place of Disposition (Name of temetery cremetory or other place, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Linesee ter the disease, or complications that caused the death. Do not enter the mode of dying, such as heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) accident - Stroke Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Lue to for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No rostate Cancer é Completed

Physician /Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Marylend nent of Health end Mental Hygiene.

Baltimore,

permit. Page Department of

To the Hospital or Attending Physician: The law requires that the death certificate be exec

this

Director:

within 24 hours after d To the Funeral Direct completely filled in by

deeth

Be

Medicai Certification: To

State

Division of Vital Records, P.O. Box 68769

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

2 No 1 Yes

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25	. Was case examiner	referred to medical	
	1 🗆 Yes	2/2 No	

27. Manner of Death 1 Atlatural

5 Pending investigation 6 Could not be determined

1 Inpatient 28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury et Work?

2 🗆 No 1 Yes

Other: 4 Nursing Home 5 Residence & Other (Specify) NOSALC 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

(Check only one) 29b. Signature and title of certifier

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

ed cause of death (Item 23e) (Type, Print) 30. Name end address of person who complete

Marvin 31. Dete filed (Month, Day, Year)

32. Registrer's Signature

29c. License number

Registrar **DHMH 16 Rev 6/95**

ORIGINAL

12020 State of Maryland / Department of Health and Mental Hygiene [] [] [] For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month 1110 HOURS **Physician** APRIL 2004 WIKINS ANN Make /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner A Bayview BAltimak & Il Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months 1 ☐ M 2 € F 212 26 5790 85 May 12, 1918 N.C Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If ten 27 is marked other than "natural" or its and the files of 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 12 Yes 2 No Bultman & Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Streel and Number 2906 21224 Highway 4.5.12 Mulaski Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□Yes 🕍 No Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPER HOUSEKEEPER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Finch May ပ DUBY unanowa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2706 15hory Padington HULaski AVONa 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State CARME! CEMETER 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bets 22. Name and Add ass of Facility Totucia CAROLINE ST BAHIMURS MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulling in death) MYOCARDIAL NEARC TION MINUTES **Physician** /Medical Due to (or as a consequence of): Examiner DISEASE YEARS THERUSCLEROTIC CARDIOVASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulling in death) Last Due to (or as a consequence of) Examiner be executed burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical ate has been signed by the attending phys page 2 should be detached for use as the Hospital or Attanding Physician: The law requires that the death certificate IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 No 2 No 25. Was case referred to medical examiner? filled in by the funeral director. 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Medical Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 55245 + DOO APRIL 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 CEASA2 BACTIMURE 21201 MD NORTH EUTHW STREET, 31. Date filed (Month, Day, Year) 32. Registrarie Signature State 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2004 April 20, **Physician** Dorothy N. Malthan 5:20 a [™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chapel Hill Nursing Center Randallstown Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Birthplace (State or Foreign Country) 1 □ M 2 F Months 216-36-6901 Yrs 95 Director JUNE 19, 1908 Pennsylvania Usual Residence of Decedent death with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "neturel", or items 23a or 28a-f show the Modical Extending roust be notified at 1 ☐ Yes 2√ No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7319 Castlemoor Road 21244 Funerai USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 X Widowed 4 ☐ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. other then " Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other the eny injury or other treumetic event, it a once. Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Spurley ဂ္ Carrie Oldhauser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Malthan/son 7319 Castlempor Road Baltimore, Mi 21244 ate 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 24 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 4/20/04 Metro Crematory, Inc. * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funera Service Licer cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. Consestue Carpio myopalh, /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consiquence of Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed b Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Feilum 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check onl one examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ပ 1 ☐ Yes 2 No 4X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) After the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a the Hospitel 17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier To t 29c. License number 29d. Date signed (Month, Day, Year) Claylan 2908 April 20 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 3310 21133 m.D. Chincu 32. Registrar's Signature State APR 2 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 12022 Certificate of Death Reg. No. 2 Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician Williams Everett Clarence 201 /Medical 4c. County of Death 4b_City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner BOHIMOVE
If Under 1 Year | If Under 24 Hrs. Social Security Number)ital (In yrs. last birthday) 8. Date of Birth (Month, Day, 07 28 Birthplace (State or Foreign Country) **Funeral** Year) Hours XXM 2 F ΜĎ Director 76 214-20-1244 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County od other than "natural", or items 23e or 28e-f show event, the Medical Examiner must be multiped at 1X Yes 2 □ No Directo Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21216 U.S.A. 2827 Clifton Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2000 Specify: þ 3 ₩ Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) Electric Company Electrician 12th grade na 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event QDGs. 17. Father's Name (First, Middle, Last) Be Marie Byrd Benjamin Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4508 Norfolk Ave, Baltimore Md Robert Williams-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 4/21/04 Owings Mills, □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore Md 21. Signature of Funeral Service Linense 21215 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** unaemi /Medical Due to (or as a consequence of): **Examiner** Societially list on flions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a onsequence of): spital or Attending Physician: The law requires that the death certificate be executed tours after death.

neral Director: After this certificate has been signed by the attending physicien and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of Division of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2□ No 2 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ✓ npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification; 5 Pending investigation 1 🗹 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Zadorium Name and addrs s of person who completed cause of death (Item 23a), (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 0 2004 Registrar

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 0 2004

32. Registrar's Signature

			1 - For State Registrar	State of M	Marylan	d / Depa	artment of I	lealth and <i>Death</i>	d Mental Hy	giene Reg. No	2004	12024
	Physici	an	Decedent's Name (First, Middle,	•					2. Date of D Month	eath Da	y Year	3. Time of Death
	/Medi			orden					APRIL	- 1	7 4007	13:40 M
	Examir	ner	4a. Facility Name (If not institution, I		r)		4b. City, Town, o	or Location of De Cimore	ath	40	. County of Death N/A	
-70	Funeral				ge (In yrs.	last birthday)	If Under 1 Year	if Under 24 H	Irs. 8. Date of Bi	rth	O Birth	place (State or Foreign
	Director		212-01-9725	1 ☐ M 2 X XF	8	84 Yrs.	Months Days	Hours M	April	22,19	919 Mar	yland
7	2		Usual Residence of Decedent 10a, State 10b, County		10c Cit	y, Town or Lo	Nostina.					
ole of	sho	5	Maryland N/	A		Baltim						10d. Inside City Limits 1
4	28e-1	Director	10e. Street and Number				10f. Zip Code			10a. Cit	tizen of What Cou	
1	deatri with the Maryland ms 23a or 28e-f show		3838 R	oland Avenu	ıe Apt	.502		211		•	USA	
	oean dean	Funeral	11. Marital Status	12. Was Decedent	t Ever in U.	.S. 13.	Was Decedent of H	Hispanic Origin?	(Specify Yes or No erto Rican, etc.)	0-	14. Race - Ameri Black, White,	
0	ined within 7.2 flours after deaff with the Marylan fall Hygiene. Ital Hygiene. Id other than "natural", or items 23a or 28e-f show event, Ina Macilical Ext., intelf., and be retified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced		No		1 ☐ Yes XX No		ono moan, etc.,			white
3 3	atura		15. Decedent's	Education		16a. Dece	dent's Usual Occup	pation		16b, K	ind of Business/Ir	ndustry
Z1Z15-0036	within 72 ene. than "nai	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	r 5+)	(Give	kind of work done DO NOT use retire	during most of w d)	vorking			
- 7	Hygien Hygien Sther th	Con	12th		·	Sale	es clerk				tail sto	res
	even	Be	17. Father's Name (First, Middle, La Kenneth Earl	·				18. Mother's N	lame (First, Middle		,	
2	and Mental Is marked or sumatic eve	10	19a. Informant's Name/Relationship			10b Maili	na Address (Straat	and Number or	Dorothy Rural Route Numb			-0-4-1
	s tand 2 should if Health and Men item 27 is marke other traumatic		Patricia A. Coso		nter		ce House		Stewart			
.	f Hea item		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other pla		Date		ocation - City or To	L7363 own, State
artimor	nent of net: # it int: # it		1 ☐ Burial 2 🖫 Cremation 3 1 ☐ Donation 5 ☐ Other (Spe		Bal	timore	e-Washing	ton 4/:	21/2004	Lau	rel, Mar	vland
	Deportment of find or		21. Signature of Funeral Service Lie	censee)		D. 22	2. Name and Addre	ss of Facility	Р 1			,
ם מ	20559	<u> </u>	Kan	argente	u		DJI TALLS	Koad	z Funeral Baltimor	·e [V	ne, Inc. Maryland	21211
			23a Part1. Enter the disease, or co shock, or heart fallere. List or	omplications that cause thy one cause on each I	ed the death line.	n. Do not ent	er the mode of dyir	ng, such as card	iac or respiratory a	rrest,	ar y zana	Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition resulting in death)	_a SEPS	IS							Onset and Death 2 DAYS
	/Medical Examiner		resulting in death)	Due to (or as		,						
	45. 45.7	<u>-</u>	Sequentially list ronditions if any, leading to immediate	b LSCHE			ON AND	LNTES	TINES			3 DAYS
To to	d ansit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C ATHERO	SCIE	DIST	CORN	NARYVE	ISCULA	DI	SEASE	SEVERAL YEAR
X	an an rial-tr		resulting in death) Last	Due to (or as					.5-40-7		00,100	
	physician and s the burial-transit	dicai		d								
إِ لِهَ	ding p	Med	IF FEMALE:	20- 1/						T		
Son .	attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3	Ectopic pregnancy	1			23d. Date of delive Month	Day Year
j ş	the ched	ysic	1 ☐ Yes 2 Ø No 9 ☐ Unknown	4∏ Pregnant a 9∏ Unknown	at time of di	eatri 5L	Other (specify) _					
ords, r.O	been signed by the should be detached		Part II. Other significant conditions	s contributing to death I	but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did 1	obacco u	ise contribute to the	ne cause of death?
ecords,	n sign	d by							1 🗆	Yes 3	No 3□ Prob	ably 4 Unknown
	s bee	Completed							24a. Was		24b. Were auto	psy findings available
r g	s certificate has b lirector, page 2 s	E O							auto perfo	rmed /	death?	mpletion of cause of
VITAL	artifica ctor.	Be C	25. Was case referred to medical examiner?					26. Place of D	eath Check onl	· ·		32.10
	his ce	10	1 ☐ Yes 2/☐ No	Hospital: 1 Inpati	ient 2 🗆	ER/Outpatien	t 3 DOA Oth	er: 4 🗌 Nursing	Home 5 Resi	dence	6 □Other (Specif	y)
	Miter t	on:	27. Manmer of Death 1. □ Natural 5 □ Pending	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time of Injury	Wor	k?	28d. Describe	how injur	y occurred	
	tor: /	cat	2 Accident investigat 3 Suicide 6 Could not	t be				Yes 2 □ No				
UIVISION	after of Direct of in by	Certification:	4 Homicide determine	ed 286. Place of in	njury - At no atc. (Specify	me, tarm, str	eet, factory, office		City or To		d Number or Rura)	I Route Number,
Hospit	within 24 hours after death. To the Funerel Directors After this certifical completely filled in by the funeral director.	edical C	29a. Certifier Check only one) Certifying 2 Medicel Ex	Physicien: To the best reminer: On the basis of and manner st	of examinal	wledge, death tion and/or in	n occurred at the tirvestigation, in my o	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) date and	and manner as si place, and due to	ated. the cause(s)
40	withir To th comp	Me	29b. Signature and title of certifier	Su	IRGIC	AL	29c. Licens	e number		29d. Dat	e signed (Month,	Dey, Year)
,			Allan	P.	ESIDE	The	AT-21	438946-	P41	AP	RIL 17th	2004
	4		30. Name and address of person when AL ADDASI, MD	no completed cause of a	death (Item	23a) (Type,	Print) DEPART	MENT O		4 -1	HEON MER	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registr	trar's Signa	ture			OUT THINK	1-1	12 mal 3	
	Registr	ar	APR	2 0 200	13-50	100	Losaffe	-5				
DHMI	H 17 Rev 1/2	001		2	4		CSF .					

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ORIGINAL

			For State	State of Maryland /	Departmen	nt of Health and M te of Death	Mental Hygier Reg. I	ne 2004	12025
			Registrar 1. Decedent's Name (First, Middle, Last)		00/11/104		2. Date of Death		3. Time of Death
	Physicia		Shellda Ja	net White	e		Apr. 2 5	Day Year	5:45 PM
*	/Medic Examin		4a. Fecility Name (If not institution, give s		4b. City	, Town, or Location of Death		4c. County of Death	1
			Franklin Squar			sedale			re
	Funeral		5. Social Security Number 6. Sex	M 2 F F	birthday) If Under Months	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth	9. Birth	intry)
6	Director	•	Usual Residence of Decedent	7 50			11400, 9, 19	12511114	rylana
	nylan how		10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
	Ba-f	Director	Maryland NA	B	altime	ore_			1 Yes 2 No
	with the		10e. Street and Number	00/000	10f. Z	p Code	10g. (Citizen of What Cou	intry?
	death with the Maryland me 23a or 28a-f ehow rmust be notified at	Funeral	11. Marital Status	2. Was Decedent Ever in U.S.	13. Was Dece	odent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Amer	
0	after or itan		1 Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	If Yes, spo	1.4	Rican, etc.)	Black, White	, etc.
3		d by	3 Widowed 4 Divorced	Year or Dates:		/ -		Specify: B	ack
7	s filed within 72 hours I Hygiene. other than "natural", ent, tre Medicel Exe	Completed	15. Decedent's Educ (Specify only highest grade	completed)	6a. Decedent's Usi (Give kind of w life. DO NOT)	ork done during most of worl	king 16b.	. Kind of Business/I	ndustry
7 7	d withi	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Care	Provide	r	Priva	te
	be filed withintal Hygiene. Id other then event, tre M	BeC	17. Father's Name (First, Middle, Last)	1. 1		18. Mother's Nam	e (First, Middle, Maid	en Sumame)	
ya		To [Charles M	lilson		1040	e Wh	ite	
Маг	s 1 and 2 should 1 Health and Mer Item 27 is marke other treumatic		19a. Informant's Name/Relationship (Type	pe, Print) (Son) 1	9b. Mailing Addres	s (Street and Number of Ru	ral Route Number, Cit	y or Town, State, Z	D Code)
<u>ရ</u>	1 and Healt tem 2		20a. Method of Disposition		of Disposition (Na		Dete 20c.	Location - City or 1	own, State
Ē	m O		1 Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	emoval from State	nell Mon	Operated 4/1	4/2004 7	runda	IK Md
Saiti	permit. Page Department Importent: If any injury of once.		21. Signature of Funeral Service License	000	-promise	nd Address of Facility	Esperi	U- ma	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
מ	89 = 8 9		Joseph	L. Russ	12222 J	N. North Ave	. Balto.	Man 217	216
			23a. Pert. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the death. De cause on each ne.	Oo not enter the mo	de of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
•	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	MOXIC	Ence	phalopathy		-	Zweeks
	Examiner			Due to (or as a consequence		10			2 weeks
3	* 1	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence					7,50
1	and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Diabete	- Nel	75			years
2	ician buria		Tosaining in double, East	Due to for as a consequence	tal.	Renal dis	lase		(Man)
780	के हैं व	edlcal	d	21,4	J.	473	CASC		Jeny-
ROX	death certific e attending p id for use as f	M/u	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal dea		NACCO CON		23d. Date of delin	very
	b death	Physician/Me	in the past 12 months? 1 Yes 2 o	4 Pregnant at time of death				Month	Day Year
r O	uires that the de i signed by the a id be detached f		9 ☐ Unknown Part II. Other significent conditions con	tributing to death but not resulting	o in the underlying	cause given in Part I	23e Did tobacc	o use contribute to	the cause of death?
as,	The law requires that ite has been signed b page 2 should be deta	d by	Tank Still S		g in the anconying	ouddo gwommi aren.	1 🗆 Yes		1-6
cord	w requires been si	Completed					24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
Y Y	sician: The law certificate has b irector, page 2 s	omi					autopsy performed 1 ☐ Yes 2 ☑	? deeth?	
Vitai	ysician: is certifica director, p	ВеС	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one)		
0	this d	P	1 □ Yes 2 No		Outpatient 3 C		ome 5 Residence		ify)
	fe and	tion	27. Manner of Death 1 Salatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yeer) 28b	b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ijury occurred	
DIVISION	or Attending after death. Director: After in by the fune	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	, farm, street, facto	ry, office	28f. Location (Street City or Town, Str	and Number or Rui	al Route Number,
5	tal or	Certification:	4 Hollicide	building, etc. (Specify)			City of Town, Sa	110/	
	To the Hospital or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	29a. Certifier The Certifying Physical (Check only one) Medical Examination	sician: To the best of my knowled her: On the basis of examination	dge, death occurre and/or investigatio	d at the time, date and place, n, in my opinion, deeth occur	and due to the cause red at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	outhin of the comple	Mec	29b. Signature and title of pertition	and manner stated.	25	c. License number	29d. [Date signed (Month	Dey, Year)
•	- 5 H Ö) // Ch	mm		D54736		4/5/0	4
	2		30. Name and address of person who co	mpleted cause of death (Item 23)	a) (Type, Print)			D 11 -	. 1
			Dr. Kamlyn A	JUYEUNG Signature	1000 H	ranklin Sq	uare Dr.	Balto.	1d, 21237
3	Sta Registi		31. Date filed (Month, Day, Year) APR 2 0 2	A.	1 Snew	E) -			

Dale Ann Yocum 04-02642 crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- State of Maryland Dep. State of Maryland Dep. State 830, 4/28/2014	artment of Health and Martificate of Death	Mental Hygie	2004 1	2026
Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
/Media	al	Dale A. Yocum		April	17 2004 1	:51 A M
Examir	er	4a. Facility Name (If not institution, give street and number) Interstate 695, Inner Loop, near Charles Street			4c. County of Death Baltimore	
Funeral Director		5. Social Security Number 212-60-2990 G. Sex 1 M 2 XF 7. Age (In yrs. last birthday) 51 Yrs. Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 6/ (Month, Day, 16) June 4, 1	4/1952 9. Birthplac Country 953 Maryla	e (State or Foreigr nd
yland now		10a. State 10b. County 10c. City, Town or Lo	ocation		10d.	Inside City Limits
a-1s	ctor	Maryland Baltimore	Perry Hall			1 ☐ Yes 2 No
with the Maryland a or 28a-f show Le notified at	Directo	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country	?
sath w	eral	9505 K Kingscroft Terrace	21128		U.S.A.	
hours after death with the Maryland ural', or Items 23a or 28a-f show a Examinar must be notified at	by Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2.21 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1☐ Yes 2【 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Black, White, etc. Specify: Whi	·
72 nai	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	166	. Kind of Business/Indust	ry
	mple	Elementary/Secondary (0·12) College (1-4or 5+)	DO NOT use retired)		41	. 0 '
illed within Hygiene. other than		12th Grade Flic 17. Father's Name (First, Middle, Last)	ght Attendant		outhwest Ai	runes
s 1 and 2 should be filed within the Health and Mental Hygiene. Item 27 is marked other than other traumatic event, ILE M.	o Be	Thomas F. Costantini		e (First, Middle, Maid Franz	en Sumame)	
2 should be and Mental is marked (raumatic ev	2		Anna ng Address (Street and Number or Run		tv or Town, State Zin Co.	de)
alth a alth a 27 is			3 Bernard Lewis Ct			
ges 1 and 2 it of Health a if Item 27 i		20a. Method of Disposition 1 💢 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition cemetery, crem	sition (Name of natory or other place)	Date 20c	Location - City or Town,	State
permit. Pa Departmen Important: any injury	i	'4 □Donation 5 □Other (Specify) Gardens	of Faith Cem. 4/2:	1/2004 Ba	ltimore, Ma	ryland
permit. Pages Department of f Important: If Ite any injury or of	Į,	Duan Ce. Willer	Name and Address of Facility Sch 1705 Belair Rd., B	altimore,	neral Homes MD 21236	
Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Head and Chest Ingresulting in death)		or respiratory arrest,	Inte	proximate erval Between set and Death
/Medical be executed Examiner but so in the private and the private transit the private representation of the private represen	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):				
I the death certifi by the attending ached for use as	by Physician/Med		Ectopic pregnancy Other (specify)	li li	23d. Date of delivery Month Day	Year
w requires that been signed I should be det		Part II. Other significant conditions contributing to death but not resulting in the ur	derlying cause given in Part I.	23e. Did tobacc 1 ☐ Yes	o use contribute to the ca	use of death?
The taw ate has b page 2 si	Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 🔀	death?	tion of cause of
Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death			
ding After fune	Certification; To	27. Manner of Death 1 □ Natural 5 □ Pending 2 ☒ Accident investigation 1 □ Natural 5 □ Pending 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □	Work?	28d. Describe now in	6XIOther (Specify) a jury occurred Decea of a vehicl	ased was
Dir		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify) Road	l B	oop, norti	and Number or Rural Ro te) Interstate 6 1 of Charles S County, Maryla	treet.
To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death 2 Medicel Exeminer: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place, a estigation, in my opinion, death occurre	and due to the causes	(c) and manner as stated	
To the within 7	Σ	29b. Signature and the offender	29c. License number O • C • M • E •		ate signed (Month, Day, LL 17, 2004	Year)
6		30. Name and address of person who completed cause of death (Item 23a) type, F Susan R. Hogan, M.D. 11	Print) 1 Penn Street, Ba	ltimore, N	Maryland 212	201
Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Could o			

			1 - For Registrar	State of Ma	ryland / Depa Ce	artment of I			ene .n2 0 0 4	12027
	Physic		Decedent's Name (First, Middle, Last, Anthony Don					2. Date of Death Month	Day Year	3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, give		0 51.	4b. City, Town,	or Location of Dea	April	19 2004 4c. County of Death Baltimor	
	Funeral Director		5. Social Security Number 6. Security Number 086-18-7015 Usual Residence of Decedent	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days			9. Birth	place (State or Foreign ntry) ISYlvania
	death with the Maryland ma 23a or 28a-f show	ctor	10a. State 10b. County Maryland n/a		10c. City, Town or Lo					10d. Inside City Limits 1 XYes 2 ☐ No
	3a or 26	i Dire	10e. Street and Number 2416 W. Rogers	Ave.		10f. Zip Code 2120	79	10g	Citizen of What Cou	ntry?
980	or ite	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 □ No			Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White	etc.
Maryland 21215-0036	2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", raumatic event, Ire Medical Exa	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation a <i>completed)</i> College (1-4or 5+	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo d)	rking	Shipping	
yland	nould be file I Mental Hyg narked othe natic event.	To Be C	17. Father's Name (First, Middle, Last) Samuel		Amat		Eva	me (First, Middle, Mai	den Sumame) Liparı	
	s 1 and 2 st f Health and item 27 is n other traun		19a. Informant's Name/Relationship (Ty Andre Amato (son) 20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	1228	Fairway	Drive We	ural Route Number, C Estminster Date 200		21.158
Baltimore,	permit. Page Department o Important: If any Injury or once.		1 Magurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		Most Holy	Redeemer			altimore,Mr	yland
	84 2 2 8 9		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused t	b	6500 Yor	k koad Balt	imore,Maryla	nd	Approximate
	Prrysician /Medical Examiner		snock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	me	consequence (f):		e lom			Interval Between Onset and Death
8760,	cate be executed physicien and the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):					
.O. Box 6	requires that the death certificate be executed een signed by the attending physicien and hould be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 MNo 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti	Fetal death 3	Ectopic pregnanc) Other (specify)	/		23d. Date of delive Month	ery Day Year
ords, P	w requires that been signed b should be dete	by	Part II. Other significant conditions con	tributing to death but	not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did tobacc	co use contribute to the	
al Records,	The law ate has b page 2 s	Completed						24a. Was an autopsy performed	? prior to coi	psy findings available inpletion of cause of
ion of Vital	Attending Phystclan: Th r death. ector: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 Inpatient 28a. Date of Injury (Month, Day	28b. Time of	28c. Injur Wor	er: 4 ☐ Nursing H	th <i>(Check only one)</i> ome 5 ☐ Residence 28d. Describe how in		Hospico
Division	o it e	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur- building, etc.	y - At home, farm, stre (Specify)	eet, factory, office	188	28f. Location (Street City or Town, St	and Number or Rura ate)	l Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled i	Medical	one)	icien: To the best of er: On the basis of e and manner state	my knowledge, death examination and/or inved.	estigation, in my o	pinion, death occu	and due to the cause rred at the time, date	o(s) and manner as st and place, and due to	ated. the cause(s)
)	P S S S S S S S S S S S S S S S S S S S	4	29b. Signature and title of certifier	y Mily	, us	29c. Licens			Pril 19	
			30. Name and address of person who co . A . R . L & 31. Date filed (Month, Day, Year)	y GF	ath (Item 23a) (Type, F 3 M C 6	701 N	. Chorl	iz,	elto. md	2120%
	Sta Registr		APR 2 1 2004	32. Registrar	s signature	Source	· / * /			

State of Maryland / Department of Health and Mental Hygiene 2000State
Registra AMEND ITEM #22 PER FH G830 4/Ce/Mically of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** PM 2004 1:10 teri SHIRLEY MAE AKERS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Maryland Mospita Baltimore Jenera If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. FEB 22, 1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🔀 F 73 MARYLAND Director UZIZ Pasiden 2 of Teleber permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or items 23s or 28s-1 show any injury or other traumatic event, Ita Marical Examinational COME. 10a. State 10b. County 10d. Inside City Limits 10c City Town or Location BALTIMORE MD. N/A 1 Pes 2 No Director 4800 SETON DRIVE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code VILLA ST. MICHAEL HOME 21215 U.S. OF A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Specify BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ANo Specify: þ If Yes, Giro Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) COSMETOLOGIST SELF EMPLOYED UNKNOWN UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be NODIO FERGUSON JULIA MAE IRVING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KEITH IRVING (GRANDSON) 4644 PARKTON STREET BALTIMORE MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State MT. ZÍON CEMETERY 4,21,04 LANSDOWNE, MARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 755 Service 7 LEWTS^{and} 1. CWYNN FUNERAL HOME WYNN 21215-6393 Levelun -ewis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Lhronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit the death certificate be executed Due to (or as a consequence of) Box 68760 Completed by Physiclan/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the aid be detached for 1 ☐ Yes 2 ☐ No P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 ∰Unknown 1 ☐ Yes 2 ☐ No should should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 11 11 10 Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient Medical Certification; To 2 ER/Outpatient 3 DOA in 24 hours after death, the Funeral Director: After this pletely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide ō 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the F wit in 2 29b. Signature 103 title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI 30. Name and address of person who completed cause of death (Item 23a) Type, Print) M a l 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 1 2004

Concept A part March Mar	020			_ FOI	partment of Health and Mertificate of Death		ne . No. 2004	12029
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So Billar So Course So C				218-66-5637 1 [™] M 2□F 33 Yrs.		8. Date of Birth (Month, Day, Ye September 1	9. Birthpi Coun 7, 1970 Washin	ace (State or Foreign try) gton, D.C.
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Registrar ADD 2 1 7004 Sentra Departs		Str	ate	S. R., \ OGA- 31. Date filed (Month, Day, Year) 32. Registrar's Signature		Baltimor	ce, Marylan	d 21201

ysicia		 Decedent's Name (First, Middle, Last Sophia 	Bloom				2. Oate of I Month April		ž, 2004	3. Time of Death 7:15PM M
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camine		Genesis Elder Car			Silver	Spri	ng	М	lontgomer	у
neral		5. Social Security Number 6. Se	7. Age (In yrs. Ia	st birthday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min (Month.)	Dav. Yeer)	9. Birth Cou	plece (State or Foreign intry)
or		578-44-4205 Usuel Residence of Decedent	73				pept.	۱ , د ک	.910 Flaty	yland
	_	10a. State 10b. County	10c. City,	Town or Loc	ation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	× -	Maryland Montgome	ery Si	llver S	Spring 10f. Zip Code			100 Ci	tizen of What Cou	
		10e. Street and Number 3227 Bel Pre Road			20906				nited St	
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	Be	17. Father's Name (First, Middle, Last)	** 1			18. Mother	s Name (First, Midd	lle, Maider	Sumame)	** 1
	၉	19a Informant's Name/Relationship (7	ine Print	nown	Address (Street	and Number	or Rural Route Nun	ber, City	or Town, State, Zi	Unknown ip Code)
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l		20a. Method of Disposition	20b. Pla	ace of Dispos	ition (Name of atory or other place		Date	20c. L	ocation - City or T	Town, State
l		1 ☐ Burial 2 【IXCremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify		sapeak	e Cremat	ory 4	-17-2004	Вє	eltsville	e, MD
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	\dashv	23a. Part1. Enler the disease, or comp	lications that caused the death	2 93	3 Gist A	venue	Silver S	oring	, MD 20	910 Approximate
		shock, or heart failure. List only of	ne cause on each line. Pneumon		, , .		,			Interval Between Onset and Death
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	iner	if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or as a consequ	ence of):						
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Ì	calE		d							
		IF FEMALE:						Tallet		
	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3 [Ectopic pregnancy	1			23d. Date of deli- Month	very Day Year
	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of de 9☐ Unknown	atn 5∐	Other (specify) _					
	y Ph	Part II. Other significant conditions of	ontributing to death but not resu	Iting in the un	derlying cause giv	en in Part I.	23e. Di	d tobacco	use contribute lo	the cause of death?
	ed b	Coronary Artery	Disease				1[☐Yes 2	.□No 3□Pro	bably 4 🛣 Unknown
	Completed by	Alzheimer's dise	ase				24a. W	topsy	prior to o	topsy findings available ompletion of cause of
	Com						1 🗆 Yes	rfórmed? 2 ☑ No	death? 1 ☐ Yes	2□ No
	Be	25. Was case referred to medical examiner?	Hospital:		Oth		of Death Check on			
	5	1 ☐ Yes 2 ☑ No 27, Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	28c. Injur		sing Home 5 - Re 28d. Describ			ify)
	ation	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 🗍 N	o			
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			1							
	Medical	29a. Certifier 1 XCertifying Ph (Check only one) 2 Medical Exan	ysician: To the best of my know liner: On the basis of examinati and manner stated.	wledge, death ion and/or inv	estigation, in my o	me, date and pinion, death	place, and due to the control of the	ne cause(s ie, date an	d place, and due	stated. to the cause(s)
	Med	29b. Signature and title of certifier	1		29c. Licens	e number		29d. Da	ate signed (Month	, Dey, Year)
		16/11	loso V	IN	D522	61		Apı	ril 16,	2004
		I MAN K		J - 1						

			For State Registrar	State of Marylar		partment of F Prtificate of			iene _{eg. No.} 20	04 12031
\cdot \(\frac{1}{2} \)	Physici		Decedent's Name (First, Middle, Last) Roy Edward I	Battles				2. Date of Dear		3. Time of Death
>	/Medic Examin		4a. Facility Name (If not institution, give si	treet and number)		4b. City, Town, o	or Location of Death	1	4c. County of	7
	Funeral Director		2/3-24-1548		last birthda Yrs.		arrollton If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 6,	Year)	nce George's B. Birthplace (State or Foreign Country) Ohio
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or	Location				10d. Inside City Limits
	Many P-f sho	tor	Maryland Prince Ge	eorge's		Mitchell	ville			1 ☐ Yes 2√ No
	or 28e	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	nat Country?
	s 23a		10450 Lottsford Rd		10 40		721		United	
980	al', or Rem	by Funeral	11. Marital Status 1 Never Married 2 Married 3 🕅 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1.5.	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🗓 No		Pecify Yes or No- Rican, etc.)	Specify:	American Indian, White, etc. White
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28e-f show other treumatic event, II a Michael Examination and be mellined at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Giv	edent's Usual Occup re kind of work done DO NOT use retired	during most of world)	ring		ness/Industry ot./Agriculture Government
<u>5</u>	illed wi Hygien other th	Be Co	17. Father's Name (First, Middle, Last)		DITEC	COI OI Ag		e (First, Middle, M		
/lan	2 should be and Mental is marked of reumatic eve	To B	Lyle H.	Battles			Belle		Burton	
Man	l 2 sho l and l		19a. Informant's Name/Relationship (Typ		19b. Mai	ling Address (Street	and Number or Run Blvd.	al Route Number	City or Town, St	ate, Zip Code)
	Health Health tem 27 other tr		Thomas G. Battles , 20a. Method of Disposition		-	Christmas position (Name of ematory or other place		Date	OH 446 20c. Location - Ci	
timore,	Pages nent of I ent: If ite ury or o		1 ☐ Burial 2 ☒ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	anovar nom prate		ematory or other place ke Cremat	11911	1 21,		ille. MD
Balt	permit. Pages 1 and 2 Department of Health i Importent: If item 27 i any injury or other tre		21. Signature of Fuperar Service Visingles		382	22. Name and Addre Rapp Fune 933 Gist	ss of Facility ral and C Ave. Sil	remation	Service	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	cations that caused the deat		nter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
0	Physician		Immediate Cause (Final disease or condition resulting in death)	Coventy	12 H	eart fo	ilure			Onset and Death
	/Medical Examiner			Due to (oh) as a conseq	uence of):	illa				400
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):	MI 167				10003
	flicate be executed g physician and is the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					-
68760	te be e ysician te buria	edical E	€ d.							
_	± 03 m	Med	IF FEMALE:	L. M. Carlotte and Carlotte					10u	
.O. Box	The law requires that the death certifi tte has been signed by the attending tage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of depth of the second of the s	death 3	□Ectopic pregnancy □ Other (specify)	1		23d. Date of Month	
ds, P.	juires that the de n signed by the a lid be detached f	by	Part II. Other significant conditions cont	A - 1	ulting in the	underlying cause giv	en in Part I.	m		ute to the cause of death?
Vital Records,	The law require te has been si age 2 should t	Completed	Aremia					24a. Was ar autopsy perform	prio	
ı		Be C	25. Was case referred to medical examiner?				26. Place of Deat	1 Yes 2		Yes 2ENo
	Physic this ce al dire	은	1 ☐ Yes 2 ☐ No		ER/Outpatie		4 Nursing Ho	me 5 Resider		(Specify)
Division of	ding I h. After funer	ation	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Worl	y at k? Yes 2 □ No	28d. Describe ho	w injury occurred	
Divis	sel or Attenss after deat I Director: In by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, s	treet, factory, office		28f. Location (Str. City or Town,	eet and Number (State)	or Rural Route Number,
	To the Hospitel or At within 24 hours after d To the Funerel Direct	edicai	29a. Certifier (Check only one) 1 Certifying Physical Control one)	ician: To the best of my kno er: On the basis of examina and manner stated.	wiedge, dea ition and/or i	ith occurred at the tin nvestigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manne te and place, and	er as stated. I due to the cause(s)
	Tot With Com	Σ	29b. Signature and title of certifier	3 mo		047	e number 1603	R	pril 20	Month, Day, Year)
	10		30. Name and address of person who and	once in	4000	Motdell	ville Rd	B216 1	Bowle,	MO 20716
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 1 9nn	32. Registrar's Signa	iture 4	lac			7	

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State of Maryland / Department of Health and Mental Hygiene2	U	U	Į

		-	For State Registrar	State of Maryland	d / Depa	artmei	nt of Health and I te of Death	Mental Hyg	jiene2	004	120	32
			Decedent's Name (First, Middle, Last)					2. Date of Dea	th Day	Year	3. Time of I	Death
	Physicia		CLIFTON BRYANT					04-14-	2004	1 641	2:01	А м
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City	. Town, or Location of Death)	4c. Co	ounty of Death	1	
			R646 HARLEM AL	<i>I</i> ENUE		BAI	TIMORE			NA		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	-	If Unde Months	or 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birth	nplace (State or untry)	Foreign
	Director		215 · 40 · 0413	M 20 F 63	Yrs.			04-21-	1440		NC	
	and W		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside Cit	y Limits
	Aaryli sho	5	mp NA	BAI	TIMOR	F					1, ☑ Yes	2 🗌 No
	28a-	rect	10e. Street and Number		111101	_	ip Code	1	l0g. Citize	n of What Co	untry?	
	death with the Maryland ims 23a or 28a-f show ir must be notified at	Funeral Director	2646 HARLEM A	VENUE			21216			USA		
	ms 2	era		Was Decedent Ever in U. Armed Forces?	S. 13.	Was Dec	edent of Hispanic Origin? (Secify Cuban, Mexican, Puert	pecify Yes or No-	14	Race - Amer Black, White		
٥	or Ite	Ē	1 Never Married 2 Married	1 ☐ Yes 2 M No If Yes, Give		ii res, sp 1 ∐ Yes		o riican, etc.)				
2-003p	within 72 hours after death with the Marylan ene than "naturel", or Itema 23a or 28a-f show the Madical Examinat must be notified at	l by	3 Widowed 4 Divorced	Year or Dates:			Zuszito Opecny.			pecify: BU	ack	
ה	72 h	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece (Give	dent's Us	ual Occupation ork done during most of wor use retired)	king	16b. Kind	of Business/I	Industry	
Z		mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	HOME		IPROVER		COAL	STRUCT	1/M \	
Z	filed with Hygiene. other than		17. Father's Name (First, Middle, Last)	N n	VIORIL	111		ne (First, Middle,			1010	
land	be d la	Be.	OWEN BRYANT				FANNIE	·				
\rightarrow	should Ind Meni	10	19a. Informant's Name/Relationship (Type	ne, Print)	19b. Mailir	ng Addres	ss (Street and Number or Ru			own, State, Z	ip Code)	
Mar	and 2 shx ealth and n 27 is m		GLADYS BRYANT		Elalo	HARI	EM AVE. B	ALTO. M	0 2	211-		
ō,	Hear Hear		20a. Method of Disposition		lace of Dispo	sition (N	ame of	Date	-	tion - City or 1	Town, State	
Baitimore,	0 0		1 ØBurial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	amoval from State	ZION			0.04	3ALTO	OM.		
	permit. Pag Department Importent; I any injury o		21. Signatore of Funeral Service Licens		22	2. Name a	and Address of Facility	GILLEON				
ñ	80 E 8 8		2 mg C	—	5	DI B	AND NATH PIKE	BALTO.	MD ?	21229		
			23a. Part1. Enter the Isease, or complice shock, or hear failure. List only on	cations that caused the death e cause on each line.	h. Do not ent	ter the mo	ode of dying, such as cardiad	or respiratory arr	est,	1000	Approximate Interval Betwoonset and D	veen
	Physician	8 8	Immediate Cause (Final disease or condition	Comino		7 1	Hypophainy	Y			24641	
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):		1, 1					
	LAdimilei	L	Sequentially list conditions, b	. Due to (or as a conseq.	uance of):							
	led Isit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq.	derice (1).							
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760	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit		€ d									
9	tificat ng phy as th	Physician/Medical			· · · · · · · · · · · · · · · · · · ·							
Box	th cer tendir r use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		⊒Ectopic	pregnancy		23	d. Date of deli		'ear
	e dea the at	sici	1 Yes 2 No	4☐Pregnant at time of d 9☐Unknown	eath 5	Other (specify)			WOUTH		-
o.	res that the de signed by the a be detached to	Phy	Part II. Other significant conditions con	tributing to death but not res	ulting in the	ınderkina	cause given in Part I	23e. Did to	bacco use	contribute to	the cause of de	eath?
S,	signe be c	1 by	Patti. Other agrinount containers con	thousand to dodn't but not not	anny in the a	in conyung	00000 9.707.117. 0.11	12Y			obabiy 4 🗀 U	
Ö	w require been sig should t	ete						24a. Was a	10	24h Were au	topsy findings a	available
Re	ne lav s has ge 2	Completed			 			autop: perfor	sy med?	prior to death?	completion of ca	iuse of
ā		e Co	25. Was case referred to medical				26 Place of De	1 ☐ Yes ath (Check only or		1 L Yes	2[]/No	
5	/sicie s cert	To B	evaminer?	ospital: 1 Inpatient 2	ER/Outpatie	nt 3□ [Other	lome 5 Resid		Other (Spec	city)	
o	£ = a		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		28c. Injury at Work?	28d. Describe h	ow injury	occurred		
0	Attending Ph ar death. ector; After th by the funeral	atio	Natural 5 Pending investigation	(Mona, Day roar)	mqury	М	1 Yes 2 No					
Division of Vital Records,	or Attending Physicien: ifter death. Director; After this certification by the funeral director, in	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)		reet, facto	ory, office	28f. Location (S City or Tow		Number or Ru	ral Route Numi	ber,
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	To the Hospital or Attending F within 24 hours after death. To the Funeral Director; After completely filled in by the funer	Medicai	29a. Certifier Certifying Phys (Check only 2 Medicel Examir	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deal ition and/or in	th occurre nvestigation	ed at the time, date and place on, in my opinion, death occu	e, and due to the durred at the time, d	ause(s) ar date and p	nd manner as lace, and due	stated. to the cause(s)	j
	ithin ithe	Mec	29b. Signature and title of certifier	and mainer stated.		2	9c. License number		29d. Date :	signed (Month	n, Day, Year)	
•	F ≯ F ŏ		> Philip	Com			124321		11	21/00	1	
	3		30. Name and address of person who co	mpleted cause of death (Item	n 23a) (Type,	. Print)	- BALLIM	-	4.0	7.7.	1	
Į.			821 N. Entraw	Street, Si	rite:	305	BALTIM	ore, n	ND.	6166	J (
		ate	31. Date filed (Month, Day, Year) APR 2 1 2004	32. Registrar's Signa	ature 4	10	no No 1					
	Regist	ıaı	MEN W T 7004	Last .	1-	2010	and the state of t					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2004 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Louis R. Butcher, Sr. 19:38 M 14,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAUTIMORE
If Under 1 Year If Under 24 Hrs. N/A AGNES ITEALTH CARE 5. Social Security Number Birthplace (State or Foreign Country)
 MD **Funeral** 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **½**□M 2□F Months Days Hours 216-36-4768 Director 65 Jun 21, 1938 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is markad other than "natural", or Itams 23a or 28a-f show othar traumatic evant, the Medical Erantrer must be notilised at Baltimore Yes 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21223 605 S. Bentalou Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 22 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nnt: If itam 27 is markad other than "natural", or Itel 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black þ 3 ☐ Widowed 4 € Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Holiday Inn Head House Man 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary J. Butcher 2 Nathaniel E. Butcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607 S. Bentalou Street Baltimore, Maryland 21223 Mary E. Butcher Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. LOUDON PARK 4/20/04 * 4 ☐ Donation 5 ☐ Other (Specify) BALTO. MD. 22. Name and Address of Facility Estep Brothers Funeral Home P.A. 1300 Eutaw Place Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death MYOCARDIA Pnysician INFARCTION disease or condition resulting in death) INKMOUNT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of) Examiner this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ №6 1 Inpatient 2 ER/Outpatient 3 DOA ŏ funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO051865 ils 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CURTIS HARUES 1405011MZ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 1 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 6:00 PM Dorothy Helen Birmingham **Physician** 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE ST AGNES HEALTH CARE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 78 Months 1 ☐ M 2 🗓 F June 18, 1925 Maryland **Director** 220-14-0285 Usual Residence of Decedent 10b. County N/A 10c. City, Town or Location Baltimore 10d. Inside City Limits 10a. State Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other treumatic event, the Madical Examination and once. 28a-f show 1 XYes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21230 U. S. A. 2203 Langley St. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify Specify: White à 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Wonnie Miles Joseph Betz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21229 George J. Birmingham, son 810 Unetta Ave. Baltimore, MD. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition MD Wetteranios Cemetery 1 XBurial 2 Cremation 3 Removal from State 04-23-04 Crownsville, MD. * 4 ☐ Donation 5 ☐ Other (Specify) of Crownsville 21. Signature of Funeral Service Licensee Ambrose Funeral Home, Inc. Espece. 1328 Sulphur Spring Rd. 21227 Arbutus, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) WC1005W Pnysician METHBOLIC /Medical Due to (or as a consequence of): FAILURE **Examiner** ACUTE RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Examiner use as the burial-transit Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 4 Unknown MYELOWA MULTIPLE 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 1 ☐ Yes 2 ☐ No this certificate 1 Yes 2 No of Vital 25. Was case reterred to medical 26. Place of Death (Check only one) funeral director, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA မ 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Hospitel or Attending After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d

To the Funeral Direct
completely filled in by filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier APRIL 80060(05) newsv 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) 900 CATOM HERSOM UCS 31. Date filed (Month, Day 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

BIR MING HAW

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State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2004 Blackwell April 9 11:30 PM Joel Dulaney /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner P.G. Bowie Larkin Chase Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 M 2 □ F Wash. 1933 70 Director 579**-**42**-**0643 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County is 23a or 28a-f show XXYes 2 No P.G. Lanham Direct with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20706 10404 Buena Vista Ave. Funerai death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Iten any injury or other traumatic event. Ite Mudical Examiner 900. 1 XYes 2 □ No If Yes. Give 1 Never Married 2K Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Specify: 1963 þ Black 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) METRO 12th Bus Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Dulaney John P. Blackwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Wife) 10404 Buena Vista Ave. Lanham, MD 20706 Kathy Powell-Blackwell 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition April 16, 2004 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham Vet. Cemetery Cheltenham, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licensee + rt1. Enter the discusse, or a implications that caused the discussion of the rest in the mode of dying, such as cardiac or respiratory arrest, additional caused on each line. N.W. WDC 20011 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) day : Physician /Medical Due to (or as a consequence of): Examiner POK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, the attending physician by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day detached for 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 1 ☐ Yes 2 ☐ No 1 Yes filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Pursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Tes 2540 28a. Date of Injury (Month, Day Year) 27. Manner of dath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 → Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No М within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 🔀 🗷 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certain 'and, #220, Bowe-MD-2076 P 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

04-2519 amend item 23a, Part II, PER ME, G832, 6/30/04eg B.K.S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. HOWARD BARRETT JR. JR. State of Maryland / Department of Health and Mental Hygiene 1 - For State Unpend Item#23a,27,28a-f, Per ME, C830, 1/23/19/28e of Death Reg. No. 12036 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 13, 10:30 A M APRIL 2004 Barrett Howard /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number)
SINAI HOSPITAL 4b. City, Town, or Location of Death Examiner BALTIMORE CITY 9. Birthplace (State or Foreign Country) Mary land If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2□F 212-78-7452 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show or other traumatic evant, the Medical Examiner must be notified at 1 Yes 2 □ No Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Items 23a or 21207 4604 U.S. A Haddon Completed by Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural, or Item any Injury or other traumatic event, the Medical Examiner 9DCS. 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Flooring 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Clara Smith Howard Barrett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ShefronyA Baltimore MD 21207 4604 Hadden Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State Woodlawn April 16,2004 Baltimore m.D. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rugard A. Crayen Fingal Home I Gorald a Grayn 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Narcotic Intexication Intracerebral Henorrhage **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9☐ Unknown 9 Unknown been signed t should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown Cocaine Intoxication 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No certificate has the inector, page 2 st 1 Yes 2 🗆 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Mnpatient 1X Yes 2 □ No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 3/26/04 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural unknown 1 ☐ Yes 2 X No 2 Accident **CX**Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Found: in parked car 281 Location (Street and Number or Rural Route Number, City or Town, State)
Liberty Heights Ave., Baltimore City, 4 / Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and s after decreal Director: After the feature of the second of the second

(Check only one) 29b. Signature and

29c. License number O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

of death (Item 23a) (Type, Print) 30. Name and address of person who complete

14, 2004 APRIL

State Registrar 29a. Certifier

Medical

31. Date filed (Month, Day, Year) APR 2 1 2004



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					State of	Maryland		tificate		Death		leg. No. 2	004	12037
			1. Decedent's Name (I	First, Middle, La.	st)						2. Date of Dee	th Dey	Year	3. Time of Death
	Physici /Media		Robert	Edward	Brown						April			3:55 AM
	Examir		4a Fecility Name (If no	ot institution, giv	e street and num	ber)			4	4b. City, Town, or Lo			ty of Death	
, (1		н	2414 B	Willoug	hby Bead	ch Road				Edgewoo			rford	
44	Funeral Director		5. Social Security Num 230–18–695	1 i	ex XDM 2□F	7. Age (In yrs. le	st birthdey) Yrs.	If Under 1 Y Months D	Year Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 2	, Yeer) 1923		plece (State or Foreign ntry) jinia
	pue *		Usuel Residence of De 10e. Stete 10	ob. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Mary	ខ្	Maryland	Harford		Fdae	boows							1 ☐ Yes 2 X No
	r 28s	Je C	10e. Street end Number			Dage	wood	10f. Zip Co	ode			10g. Citizen of	What Cou	ntry?
	h wit	a D	2414 B Wil	loughby	Beach F	Road		2104	0			USA		
020	filed within 72 hours efter death with the Marylend Hygiene. ther than "natural", or items 23a or 28s-f show int, the Medical Examiner must be notified at	by Funeral Director	11. Maritaf Status 1 Never Married 3 Widowed 4		12. Wes Deced Armed Ford 1 Yes If Yes, Give Year or Da	dent Ever in U,S ces? 2XI No tes:		Was Decedent Yes, specify □ Yes 2X		lispenic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Ra Bl Spec	ace - Ameri ack, White, ify: Wh	
5-0	72 ho	ed	15 (Specify	5. Decedent's Ed	lucation		16e. Deced	lent's Usuel O	Оссир	ation during most of work d)	ina	16b. Kind of	Business/In	dustry
Maryland 21215-0020	uld be filed within Mentel Hygiene. Irked other than "It overs, the Mas	Completed by	Elementary/Seconds		College (1-	4or 5+)		noruse r hanic	retire	3)		Rubbei	r Manı	ıfacturer
P	Hyg other	BeC	17. Fether's Neme (Fir	rst, Middle, Last)						18. Mother's Name	e (First, Middle,			Tracturer.
<u>la</u>	Mentel Mentel arked o	ToB	Edward	(u/k)	Brow	m				Ida	Mae	Sarge	ent	
any	2 should end Men la marke aumetic		19a. Informant's Name	e/Relationship (Type, Print)		19b. Mailir	g Address (S	treet	and Number or Run	el Route Numbe	r, City or Tow	n, State, Zij	Code)
	1 end Health em 27 ther tr		Rita Butle 20a. Method of Dispos 1 XBurial 2 0	sition	_		ace of Dispo	F Will sition (Name one tory or othe	of	nghby Bear	ch Road, Date	Edgew 20c. Location	ood - City or To	MD 21040 own, State
<u><u>E</u></u>	Peges nent of I ant: If ite ury or o		4 Donation 5	Other (Specif	y)	Har	ford	Mem. G	arc					aryland
Baltimore,	permit. Peg Depertment Important: If any Injury o		21. Signature of Fune	ral Service Nicer	isee Pa	m. to		. Name and A		ss of Fecility Mo Sbury Road	cComas E d, Abing			•
	6.655		23a. Pert1. Enfer the shock, or beart for	disease, or com	plications that ca	used the death.	Do not ent	er the mode o	f dyin	ng, such as cardiac	or respiratory are	rest,	ľ	Approximate Interval Between
V	Physician /Medical Examiner	ler	Immediate Cause (Fir disease or condition resulting in death)		e	ving	cai	ncer		ive p			1.3000	Onset and Death
Box 68760,	eath certificete be executed attending physician end for use es the buriel-trensit	an/Medical Examiner	Sequentially list condiff any, leading to immicause. Enter Underly Cause (Disease or injuit that initieted events resulting in death) Las	itions, ediate ing ury	b	pour	es e conseques es e conseque es e conseques es e co	will	7.		9000			
	deal he att	Sici	Part II. Other significa	nt conditions c	ontributing to dea	ath but not resul	ting in the u	nderlying caus	se giv	en in Part I.	23b. Did to	obacco use c	ontribute t	o the cause of death?
P.0	d by t	Æ	Coma	estive	1	east	F	gila	rt	9	101	′es 2□ No	3 Pro	bably 4 Unknown
Records,	The law requires thet the death centete has been signed by the attendingege 2 should be deteched for use	Completed by Physician/M	Drahet	les /	Well.	tus		7,0			24a. Was e		av	ere autopsy findings vailable prior to empletion of cause
Rec	sician: The law certificete hes b lirector, pege 2 s	E E	4 00	1							.00	35 2 XNU		death?
7	n: The ficete or, pe		25. Was case referred	TOP 3/	on					26. Place of Deat	1 D Y		1	Yes 2 No
of Vital	sicia certi	o Be	examiner?		Hospital:	patient 2 E	R/Outpatien	t 3 DOA	Oth	or:	me 5 StResid		ther (Speci	60
o	this alo	٦: ح	27. Menner of Death	`	28e. Date of	Injury	28b. Time of		Injur Wor		28d. Describe h			.,,,
ion	Attending Physician: or death. ector: After this certific by the funeral director,	atio	12 Naturel 2 ☐ Accident	5 Pending investigation		i, Dey Year)	Injury	м		Yes 2□No				
Division	or Atter fter des lirector	rtific	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	Zoe. Piece	of Injury - At hor g, etc. (Specify)	ne, farm, str	eet, factory, of	ffice		28f. Location (S City or Tow		ber or Run	al Route Number,
	To the Hospital or Attending Physician: The Is within 24 hours efter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, pege	edicai Certification:				sis of exeminati				ne, date and place, pinion, death occuri				
	To the within To the comple	Me	29b. Signature and titl	le of certifier	·KI	1	in	29c. Li		e number 7 4933	4	29d. Date sign		Dey, Year)
	6		30. Name end eddress	s of person who	completed cause	of death (Item	23a) (Type,	Print)						
	5		ROBERT S.	Kni6k	am, t	104	Plur	. 1		RD+100	r Re	elair	m	7 51012
	Sta	- 1	31. Dete filed (Month,			gistrer's Signati		Span						
	Regist	ar	APR	2 1 200	4 /		/	March						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** CHANDLER SR APRIL ALEXANDER 2004 16 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE BON SECOURS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 15€M 2□ F 38 815 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "netural", or Items 23e or 28a-f shov the Medical Examinational be routilled at 1 Yes 2 □ No MD BALTIMORE Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 Hollins 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOSPITAL CHEF 10th grade permit. Pages 1 and 2 should be fite Department of Health and Mental Hy Important: If item 27 le marked other eny injury or other treumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ROYCHANDLER EASTER WELLS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BALTIMORE, MD 21223 CHRISTING CHANDLER 2511 W. HOLLINS STREET 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State BALTIMORE, MD ARBUTUS 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility VAMETAN C. GREENE FUNERAL SERVICES SIST BALTIMORE NATIONAL PIKE BALTIMORE MD 21229 21. Signature of Funecal Service Lice /am Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) Pnysician ELECTROLYTE INDISALANCE DAYS /Medical Due to (or as a consequence of) Examiner GASTRO-INTESTINAL MALIGNAN PRO134131E UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or intury that initiated events resulting in death) Last Examine 11 certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-transit HEART DISEASE ARTERIOSCLEROTIC Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Vear 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð MELLITAS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown - DIABETES Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No SEIZURES HYPOTHYROIDISAT To the Hospitel or Attending Phyeicien: within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director, t 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2/2 No ۵ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 A Naturai 5 Pending М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tniury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD. D 23300 Apxil 16 2004

State Registrar

DHMH 17 Rev 1/2001

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2000W.

SECUDRS

KUSP.

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

SUDMIR.

APR 2 1 2004

31. Date filed (Month, Day, Year)

D. PATEZ

82. Registrar's Signatura

		•	1- For State of Maryland / Depa	artment of Health and M rtificate of Death		ene . No. 2004	. 12030
	Physici		1. Decedent's Name (First, Middle, Last) MATTIF Po. CANTY		2. Date of Death Month	Day Yeer 1 2004	3. Time of Death OB: SCAM
	/Medic Examin		4a. Facility Name (If not institution, give street and number) ST AGMES HEALTH CARE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death BALT IM TO SEL If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Deeth	
	Funeral Director		213 - 1 C - 5000 1 M 20€F ∩ Yrs. Usual Residence of Decedent	Months Days Hours Min.	(Month. Dav. Y	1913 Co.	intry) SC
	e-f show	ctor	10a. State 10b. County 10c. City, Town or Lo BACT	cation IMDRE			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th with the 23a or 28 list be no	ai Director	10e. Street and Number T12 N. Payson Street	10f. Zip Code 21217	10g	Citizen of What Cou	
036	72 hours after death with the Maryland natural; or Items 23a or 28e-f show dical Examilier result by motified at	by Funerai	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No	Nas Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto I I □ Yes 2 ØNO Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	, etc.
21215-0036	be filed within 72 hours after des ttal Hygiene. Ind other than "natural", or Items event, Ite Medical Examination	Completed	(Specify only highest grade completed) (Give life. [dent's Usual Occupation kind of work done during most of workin DO NOT use retired) TOMEMAKER	ng 16	b. Kind of Business/Ir	
Maryland	should be file and Mental Hy marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) RUBIN ROSE BOROUGH	18. Mother's Name	, , , , , , , , , , , , , , , , , , , ,	iden Sumame)	
-	1 and 2. Health ar em 27 is ther trau		LERDY CANTY / 50N 712 20a. Method of Disposition 20b. Place of Disposition	natory or other place)	reet B	altimore c. Location - City or T	_ MD 21217 own, State
altimore	permit Pages Department of Important: If it any injury or o		'4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee	Name and Address of Facility	-	SERVICES	
8	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. GRAM NEGA Due to (or as a consequence of):	er the mode of dying, such as cardiac of FIVE SEPS	ATIONAL respiratory arrest	PIKE BALTI	Approximate Interval Between Onset and Death DAYS
8760,	ate be executed hysician and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. URIMARY T Due to (or as a consequence of): c	RAM TYPECT	700		04743
.O. Box 6	that the death certificate ed by the attending phys detached for use as the	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
rds, P	law requires that as been signed t 2 should be det	by	Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part I.		cco use contribute to t	
Vital Records,	The la ate has page 2	Completed			24a. Was an autopsy performed 1 Yes 2	24b. Were auto prior to co death? No 1 \sum Yes	opsy findings available impletion of cause of
Division of Vita	To the Hospitel or Attending Physician: Th within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director, pag	Certification; To Be	25. Was case referred to medical examiner? 1	28c. Injury at	ne 5 Residence 8d. Describe how	nt and Number or Rura	
۵	ne Hospitel or Attend n 24 hours after death ne Funerel Director: , pletely filled in by the f	edical Cer	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the basis of examination and/or invariant manner stated.	occurred at the time, date and place, a estigation, in my opinion, death occurre	nd due to the caus	e(s) and manner as s	tated. o the cause(s)
•	10	Me	29b. Signature and title of certifier (MD) B. Afternahme	29c. License number P - 15632		Date signed (Month,	
	0		30. Name and address of person who completely cause of death (Item 23a) (Type, F 900 CA TUN AVE NOE, BAC (MORE) 31. Date filed (Month, Day, Year) 32. Registrar's Signary of the person who completely cause of death (Item 23a) (Type, F 900 CA TUN AVE NOE; BAC (MORE)	mD 21229.	DRCY	CLOPEA	ANAKWA
16	Sta Registr		APR 2 1 2004	rocks			

NAME CANTY, MATTIE B

			1 - For Amend Items 16	State of Maryla	nd (Pep	artment of H	lealth and M	ental Hygie	ene 2001	+ 12040
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	UGENE	63	PER		2. Date of Death Month	Day Year 20 , 2004	3. Time of Death 11:55A M
	Examin - Funeral	ier	5. Social Security Number 6. Sex	ON EXTENDED 7. Age (in yrs	CARE 5. last birthday,	4b. City, Town, or If Under 1 Year Months Days	BALTI If Under 24 Hrs. Hours Min.	MORE 8. Date of Birth (Month, Day,)	4c. County of Dea	Athplace (State or Foreign
- 8	Director		212-52-2512 Usual Residence of Decedent 10a. State 10b. County	M 2□F 56	Yrs.		110013	01-01-19	48	10d. Inside City Limits
	h the Mary r 28a-f sh	Director	MO NA 10e. Street and Number	BA	UIMOR	10f. Zip Code		10g	J. Citizen of What C	1 XYes 2 □ No ountry?
9	within 72 hours after death with the Maryland jiene. rthen "natural", or ttems 23a or 28a-f show the Medical Evantret must be notified at	Funeral	525 HAZLET AVE	2. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give	U.S. 13.	If Yes, specify Cuba	ispanic Origin? (Spen, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Am Black, Whi	te, etc.
Maryland 21215-0036	within 72 hours. ene. then *naturel', us Medical Exal	Completed by	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	Year or Dates:	(Give	dent's Usual Occupa	ation during most of workin	9	b. Kind of Business	
land 21	d be filed ental Hyg ced othe c event,	To Be Con	12.TH GRADE 17. Father's Name (First, Middle, Last) WARREN COOPER.	N/A	A		Lth Assist 18. Mother's Name MARJORIE	(First, Middle, Ma	iden Surname)	CARL
Mary	nd 2 shoul lith and Me 27 Is marl r traumati		19a. Informant's Name/Relationship (Type CARLETHEA NORRIS	ne, Print)		ng Address (Street a	and Number or Rural		City or Town, State,	
Baltimore,	00		20a. Method of Disposition 1 Serial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	Place of Dispo cemetery, cre-	position (Name of matory or other place) FOREST	Da	ate 20	c. Location - City or	Town, State
Baltii	permit. Pag Department Important: I any injury o		21. Signalure of Funeral Service with se		VA	2. Name and Address	S OF FACILITY FUNE BENE FUNE IATL' PIKE,	RAI SERV	ICE	TUS, MID
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any legisling to immediate	Due to (or as a conse	ath. Do not en	ter the mode of dying		respiratory arrest		Approximate Interval Between Onset and Death ONE MONTH
8760,	death certificate be executed e attending physician and d for use as the burial-transit	ledicai Examiner	d any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse						·
.O. Box 6		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Ic. If yes, outcome of pregr 1 □ Live birth 2 □ Fel 4 □ P*egnant at time of 9 □ Unknown	el death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
rds, P	ires tha signed d be dei	by	Part II. Other significant conditions conditions	tributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did tobac		o the cause of death?
Division of Vital Record	The law ate has b page 2 sl	Completed		LLITUS				24a. Was an autopsy performe	d? rior to	utopsy findings available completion of cause of
of Vit	Physicien: This certificated director, p	To Be	1 195 2 X 140] ER/Outpatier	nt 3 DOA Othe	26. Place of Death	10.00	e 6 □Other (Spe	city)
sion o	ding h. After funel	ertification;	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	at 28 ? (es 2 □ No	3d. Describe how	injury occurred	
DIV	= 00 >	O	4 Homicide determined	28e. Place of Injury · At i building, etc. (Spec	ify)	,	4	City or Town, S		
	To the Hospitel or A within 24 hours after To the Funeral Directompletely filled in by	edical	29a. Certifier 1 Certifying Physical Check only one)	cian: To the best of my kner: On the basis of examinand manner stated.	owledge, deat ation and/or in	h occurred at the time vestigation, in my op	e, date and place, ar sinion, death occurred	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
)	To t To t	M	29b. Signature and title of certifier	Tan. M	10.	29c. License	4958	29d.	Date signed (Monta	h, Day, Year)
	3		30. Name and address of person who cor	npleted cause of death (Ite	m 23a). (Type.	PrintRaven	Bouleva	nd Balt	incre M	D 212-18
5	Sta Registr		31. Date filed (Month, Day, Year) APR 2 1 2004	32. Registrar's Sign	agure Ly	rocks				

				For State of Maryland / De			•	•
					Certificate of D			2001 1001
				Decedent's Name (First, Middle, Last)	20111110410 01 2	2	Reg. No.	3. Time of Death
		Physica /Medi		Marshall Leroy Clayton		 	April /	6 2004 5:47AM
	>	Examir	ner	4a. Facility Name (If not institution, give street and number),	4b. City, Town, or I	Location of Death	44	c. County of Death
				FRANKLIN SOLARE HUSPITAL 5. Social Security Number (6)Sex 7. Age (Inlyrs. last birthe	day) If Under 1 Year	If Under 24 Hrs. 8	2 Date of Birth	9. Birthplace (State or Foreign
_		Funeral Director		217-09-4811 1X № 2□F 92 Yr	Months Days	Hours Min.	B. Date of Birth (Month, Day, Year 02/15/191)	2 Sittiplate (State of Poreign Country) Marvland
	`	pu *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	Or Landian			
ARShall		death with the Maryland Ims 23a or 28a-f show Irmust be rollfied at	ō					10d. Inside City Limits 1 ☐ Yes 2 No
S		r 28a-	Director	MD Baltimore Kings	10f. Zip Code		10g. C	itizen of What Country?
0		th with		10900 Raphel Road	21087		Ū	J.S.A.
4		tams	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of His If Yes, specify Cuban	spanic Origin? (Speci n, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.
2	0036	hours after death with the Marylar lural', or Itams 23a or 28a-f show a Exertinet must be roiffied at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☒ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 X No	Specify:		Specify: White
1	2-0	in 72 hours after death w n "natural", or Itams 23a ledics! Exeminer must b		15. Decedent's Education 16a. D (Specify only highest grade completed) ((Decedent's Usual Occupat Give kind of work done du ife. DO NOT use retired)	tion	16b. I	Kind of Business/Industry
	121	- 20	Completed	Elementary/Secondary (0-12) College (1-40r 5+)			1	
5	d 21	Hygi thar int, I		6 F'	lower Nurser	ryman 18. Mother's Name (Self-Employed
P	\subseteq		To Be	Harry Marriott Clayton			anda Eck	n comuno,
+	ary	2 should and Men Is marka raumatic	-		Mailing Address (Street ar			or Town, State, Zip Code)
~	Ž	s 1 and 2 should of Health and Mer itam 27 Is marke other traumatic			0818 Raphel			
4	, jor	0 0		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery,	Disposition (Name of crematory or other place)	1		ocation - City or Town, State
\circ	altim	permit. Pages Department of Important: If ii any injury or o		'4 □ Donation 5 □ Other (Specify) Fork U.1 21. Signature of Funeral Service Licensee	M. Church Ce			ork, Maryland un Funeral Home, P.A
	Ba	permit. Departri Imports any inju		Mother reach Chronic.	11750 Belai			· · · · · · · · · · · · · · · · · · ·
		€.	\Box	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	F	Physician		Immediate Cause (Final disease or condition HUNDX/A				Onset and Death
	•	/Medical Examiner		resulting in death) Due to (or as a consequence of)		- 1		
			e.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of)	tory 1	MAIL	re.	
		d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Classor in July that initiated events	pulmo	12016	2 015	PATE 1
	760,	te be executed ysician and ie burial-transit		resulting in death) Last Due to (or as a consequence of)		1		07,14
	9289	A A	dicai	d				
	9 x	death certificate b r attending physic f for use as the b	ician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Date of delivery
	P.O. Box	death e atter d for u	iciar	in the past 12 months? 1 Ves 2 No.	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month Day Year
	0.0	at the by th	Physi	9 Unknown				
	Division of Vital Records, I	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	by	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given	n in Part I.		use contribute to the cause of death?
	oca .	law re as bee 2 sho	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	E .	. The cate h	Соп				performed?	death?
	Vita	ician: certific	Be	25. Was case referred to medical examiner?	Othor	26. Place of Death		
	o to	Phys or this oral di	To To	27. Manger of Death 28a. Date of Injury 28b. Tim	ne of 28c. Injury a	4 Nuising nome	5 Residence d. Describe how inju	
	ion	nding ath. r: Afte e fune	atior	1. Natural 5 ☐ Pending (Month, Day Year) Inju 2 ☐ Accident Investigation	ıry Work?	? es 2 □ No		
*	ivis	r Atta ter des iracto iracto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	281	f. Location (Street ar City or Town, State	nd Number or Rural Route Number,
10	٩	pital o		On Continue of Continue Physician T		- to		
		a Hos 24 ho a Fun letely i	dical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, d Check only one) Certifying Physicien: To the best of my knowledge, d and manner stated.	or investigation, in my opir	nion, death occurred	at the time, date and	d place, and due to the cause(s)
		To the withir To the comp	Me	29b. Signature and title of certifier	29c. License r	number	29d. Da	ite signed (Month, Day, Year)
		1		IsDie MD	D55	306	APR	16, 16 2004
		10		30. Name and address of person who completed cause of death (Item 23a) (Ty	(pe, Print)	man Day	a Rais.	mo'se Md 2123
		Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	LUIN JEGG	TXICNICE	'E NAUT!	more vice olas
	1	Regist	ar	APR 2 1 2004 Server &	Sparks	*		

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 12042 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) APRIL Year **Physician** DELONA 8:10 PM 16 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HOSPITAL HARBOR N/A If Under 1 Year If Under 24 Hrs. S. Date of Birth Months Days Hours Min. July 10, 1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 🖾 F 76 218 60 9845 Yrs England | Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State worle r than "natural", or itams 23a or 28e-f ehov tre Medical Examiner must be mutified at 1X Yes 2 □ No N/A Directo Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code England 21225 606 Arsan Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White <u>Ş</u> 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedenl's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Poultry 12th permit. Pages 1 and 2 should be filed w Department of Health and Mental hygie Importent: if Item 27 is marked other tt any injury or other treumatic event, in once. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Harrison Ada Hopkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linda Chmura / Daughter 623 North Lakewood Avenue Baltimore, Maryland 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4/20/2004 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on back ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SPIRATION 2 MEEKS /Medical Due to (or as a consequence of): Examiner 6-7 MONTHS SMAL LING CANCER VON Sequentially list conditions, if any, leading to immediale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician ar Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown م. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No 1 Yes 2.1 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ⊠1npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1. SNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident i Director: the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and litle of certifier 29c. License number 29d. Date signed (Month, Day, Year) EXIERN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11401 FAWNBRIDGE DR. HAGERSTONIN RAGHAD JALIL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 1 2004 Registrar

			1 - For State Registrar	State of Maryla		artment of H			giene Reg. No. 2	004	120	43
	Physici /Medic		Decedent's Name (First, Middle, Last MARY JEANETTE	CAMPONESCHI				2. Date of De Month April	Day 18	2004 2	3. Time of De 2:30A	eath M
	Examin		4a. Fecility Name (If not institution, give 339 Rosebank Aver	nue		4b. City, Town, or Baltimor				N/A	(2)	
	Funeral Director		5. Social Security Number 6. S 216-22-3717 Usual Residence of Decedent	ex 7. Age (<i>in yi</i>	rs. last birthday, Yrs.	Months Days	Hours Min		in, _{Year)} 1927	Mary l	lace (State or F itry) and	-oreign
	Maryland a-f show	tor	10a. State 10b. County Maryland N/A		city, Town or L Baltimore					1	0d. Inside City	
	th with the 23a or 28	Funeral Director	10e. Street and Number 339 Rosebank Avenue			10f. Zip Code 2121			USA	of What Cour		
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinational De notified at	b	11. Marital Status 1 Never Married XXX Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes XX No	ispanic Origin? (\$ n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	E	Race - Americ Black, White, cify: White	etc.	
Maryland 21215-0036	I within 72 ho jene. r then "natur the Wedical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12		(Give	dent's Usual Occupi e kind of work done of DO NOT use retired ninistrator	during most of wo	orking		f Business/Ind Versity	dustry	
yland	should be filed with nd Mental Hygiene marked other the imatic event, the	To Be C	17. Father's Name (First, Middle, Last, Franklin Milford Case				Alma	me (First, Middle Ruth Shac	kelford			
	and 2 sho Baith and n 27 is my		19a. Informant's Name/Relationship (J.D.White	Husban	d 339 Ro	ing Address (Street a Sebank Aveni	ue Baltimo	ore, Maryla	and 2121	2		
Baltimore,	Page nent o ant: If ary or		20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	Removal from State	cometery, cre llcrest M	osition (Name of matory or other place femorial Pari	k 4.	Date 22-04	Annapol		'land	
Balt	permit. Pa Departmer Important any injury		21. Sonature of Funeral Service Licer	en Kenak	us)	2. Name and Addres	6500 Yor	tchell-Wie k Road Bal	timore,			•
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		nson		g, such as cardia	c or respiratory a	rrest,		Interval Betwee	
760,	te be executed ysician and e burial-transit	cal Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons c. Due to (or as a cons								
.O. Box 68	The law requires that the death certificat ale has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Tho 9 Unknown	23c. If yes, outcome of preduction 1 Live birth 2 Fig. 4 Pregnant at time of 9 Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)			1	Date of delive Month	ery Day Yea	ar
0	quires that n signed b uld be deta	by	Part II. Other significant conditions of	contributing to death but not r	resulting in the	underlying cause give	en in Part I.	23e. Did t			ne cause of dea ably 4 ⊟Unl	
I Records,		Completed						24a. Whas auto perfo 1 ☐ Yes		prior to con death?	psy findings avi impletion of cause 2 No	allable se of
f Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	ent 3 DOA Oth	0.00	Home 5 Aesi		Other (Specif	· ·	LS
Division of	fe ine	Certification:	27. Many r of Death 1 atural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b			M 1 🗆	/ at k? Yes 2 □ No	28d. Describe				
Divis	or In l		4 Homicide determined	building, etc. (Spe	ecify)			28f. Location (City or To	wn, State)			ν,
	the Hospital hin 24 hours a the Funeral I	Medical	(Check only 2 Medical Examone)	nysician: To the best of my liminer: On the basis of examiner and manner stated.		nvestigation, in my o	pinion, death occ		date and place	e, and due to	the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier	Gulf		29c. Licens	#1697		29d. Date sig	ined (Month,	Day, Year)	4
	J		30 Name and address of person who	ri)) 10=	+70 H	Print)	Ridge	e Rd	Colux	ubin	MD2	104
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 1 20	32. Registrar's Sig	gnature	Ann v	, i					,

			For State Registrar	State of Marylan		artmen rtificat				F	leg. No.	200!	121	71, 1,
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Elaine Bell Cod			45 65	Tau-	L section o		2. Date of Dea Month April	17, Day		3. Time-of V	Xeatti №
	Examin	er	4a. Facility Name (If not institution, give s Roland Park Place	treet and number)			alti	Location o NOYE	r Death		4C. C	County of Dear	tn	
	Funeral Director		5. Social Security Number 6. Sex 216-07-3558	7. Age (In yrs.) 7. Age (In yrs.) 92	last birthday) Yrs.	If Under Months		If Under 2 Hours		8. Date of Birth (Month, Day July 5,	1911	9. Bin Co Ma	thplace (State or buntry) ryland	Foreign
	filed within 72 hours after death with the Maryland Hygiene. ther than "neturel", or Items 23a or 28a-f show wither than "neturel", or Items 23a or 28a-f show ant, it a Modical Extra it at L. half be notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland N/A 10e. Street and Number	10c. Cit	y, Town or Lo		Code				10g. Citize	en of What Co	10d. Inside City Yes puntry?	
	th with	al D	830 West 40th Stre	et			211					SA		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "neturel", or Items 23a or 28a-f show any injury or other traumatic event, it is Mudical Examiliar in that be notified at anote.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married XX Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates:		Was Deced If Yes, spec 1 ☐ Yes X		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto P	cify Yes or No- Rican, etc.)		4. Race - Ame Black, Whit		
Maryland 21215-0036	d within 72 ho jiene. r than "netu rre M. dical	Completed by	15. Decedent's Edur (Specify only highest grade Elementary/Secondary (0-12) 12	cation e com <i>pleted)</i> College (1-4or 5+)	life.	dent's Usua kind of wo DO NOT us OMEMA	rk done d se retired;	urina most	of workin	99	16b. Kind	of Business Own Ho		
/land	ould be filed Mental Hyg arked other	To Be C	17. Father's Name (First, Middle, Last) Mabrey Barrett Bel	1				Li	llia	(First, Middle, n Keena		,		
Man	d 2 sho th and 7 is mu trauma		19a. Informant's Name/Relationship (Ty) Barbara Bell Baker	_{рв, Print)} Niece						Route Numbe			Zip Code)	
e, l	s 1 and of Healt Item 2 other		20a. Method of Disposition	20b. F	Place of Dispo	sition (Nar	ne of		-	ate		ation - City or	Town, State	
Baltimore,	Page Iment c tent: If jury or		1 □ Burial 2 XX Cremation 3 □ R • 4 A Donation 5 □ Other (Specify)	Gre Gre	enmoun	t Čem	eter	y 4	/20/				e, Maryl	
Bal	permit Depar Impor any in	Ŀ	Lennus Has	ly Kender	205			6500	York	Road Bal	timore		1 Home Inc and 21212	
	Physician /Medical		23a. Part1. Enter the disease, of complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Pneumonia Due to (or as a consec		ter tile mod	ie or dying	, sucri as	cardiac or	respiratory at			Approximate Interval Betw Onset and D 5 days	reen leath
,092	Examiner yysician and he burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consect	ular Acc juence of):	ident							3 mont	ns
.O. Box 68	death certifica e attending ph od for use as th	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 (3c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c	aldéath 3[⊒Ectopic pa ⊒ Other (sp					23	3d. Date of de Month		ear
S, D	quires that n signed b uld be deta	by	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the u	inderlying o	ause give	n in Part I.			es 2 🏋		o the cause of de robably 4 Dur	
I Record	ien: The law requires that the rtificate has been signed by th stor, page 2 should be detache	Completed								24a. Was autop perfor 1 Yes	sy	24b. Were au prior to death? 1 ☐ Yes	utopsy findings a completion of ca 2 \(\text{No} \)	vailable use of
Vital	5 8 9	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatier	nt 3 🗆 DC	Othe			<i>(Check only o</i> ne 5 ☐ Resid		Other (Spe	orba)	
of	After	-	27. Manner of Death 12. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury Work		2	8d. Describe h			cny)	
Division	tel or Attending safter death.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	fy)					City or Tow	m, State)		ural Route Numb	er,
	To the Hospitel or within 24 hours after To the Funeret Director Completely filled in Example of the Funeret Director of the F	edical	29a. Certifier Check only one) Certifying Physical Exami	sician: To the best of my knoner: On the basis of examination and manner stated.	owledge, deat ation and/or in	th occurred ivestigation	at the tim , in my or	e, date an pinion, deal	d place, a th occurre	nd due to the o	ause(s) a date and p	nd manner as place, and due	s stated. e to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier			290	c. License	number			29d. Date	signed (Mont	h, Day, Year)	
	1		Aulany D	yn mis			D35	102			Apr:	il 19, 2	004	
	Q		30. Name and address of person who con Hilary Dun M.D. 10	ompleted cause of death (Item 4 Tunbridge Road			rvlan	d 2121:	2					
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 1 200	32. Registrar's Sign	ature		aks				· ; 1			

		1	For State	State	of Ma	ryland	-	rtment tificate		ealth and N Death	Mental Hy	/giene Reg. No.	20() 4	1201	, E
			Registrar 1. Decedent's Name (First, Middle	, Last)							2. Date of D		Vaa		. Time of Death	
	ysicia		Frank	F.			DeKon	ıa			April	10^{ay}	200°4	6	:00PM	VI
	Medic kamine		4a. Facility Name (If not institution	, give street and	number)			4b. City, T	Town, or	Location of Death		4c. C	County of De	ath		
		•	514 Leighton A	ve.				Si	ilve	r Spring				tgom		
Fur	neral		5. Social Security Number	6. Sex	1 -		ast birthday)		1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D	irth ay, Year)	9. 8	irthplace Country)	(State or Forei 1vania	gn
Dire	ector		201-16-0005	1 M 2□		78	Yrs.				Oct. 2	3, 19	25 Pe	nnsy	lvania	
pur		-	Usuat Residence of Decedent 10a. State 10b. County			10c. City	, Town or Loc	cation						10d.	Inside City Limit	(S
faryla	10	5		gomery				Silve	ar Si	nring					1 ☐ Yes 2XX N	lo
the N	gran	Director	Maryland Mont:	gomery				10f. Zip		PIIII		10g. Citiz	en of What	Country?)	
with	4	<u></u>	514 Leighton	Ave.					20	0901		Un	ited S	State	es	
leath	Z.ME	Funeral	11. Marital Status	12. Was I	Decedent E	ver in U.	S. 13. V	Vas Deced		spanic Origin? (Si n, Mexican, Puerti	pecify Yes or N		4. Race - Ar	merican I		
fter o	il de	Fun	1 ☐ Never Married 2 ☑ Marr		d Forces? es 2 ☐ N , Give	o				Specify:	o rican, etc.)	1	Black, Wi	- 2.2111		
ours a	Exa	by	3 Widowed 4 Divorced	Year	or Dates:W	W II		∏Yes 2	X	Specify.			Specify:		nite	
72 hc	ES .	Completed	15. Deceden (Specify only highes	t's Education at grade complet	ted)		16a. Deced (Give	kind of won	k done d	uring most of wor.	king		d of Busine: oral (rnment	
t ig	N N	gr	Elementary/Secondary (0-12)		ge (1-4or 5-	+)	1	OO NOT us Prsone		pecialis	t.				Interi	or
lygier F	9		17. Father's Name (First, Middle,		5+					18. Mother's Nan						
T be fi	A A	Be		arles)		Dek	Cona			Christ	ine		(Una	avai:	lable)	
id yid iid X 1X 13-0000 2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "naturel", or thems 23a or 28s-f show	matic	은	19a. Informant's Name/Relations				19b. Mailin	a Address	(Street a	and Number or Ru	ral Route Num	ber, City or	Town, State	, Zip Co	de)	
d 2 sl	traut		Tanya DeKona /							Ave., T				2091:	_	
Heal	other		20a. Method of Disposition	Daugne		20b. P	lace of Dispo	sition (Nam	ne of	al l	Date		ation - City			
ages ont of	y or c		1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (S		rom State		sapeak	-		Apri	1 14, 004	Ве	ltsvi	11e,	MD	
DESILITIONE, INICITY STATES TO THE TOTAL OF THE MATCH PROPERTY PROPERTY OF THE MATCH PRO	injur		21. Signature of Funeral Service		-	One				s of Facility ral and		on So	rui oo			
Deg deg	any ir		Stall A	huncur	n n	100 38		33 G	ist A	Ave., Si	lver Sp	ring,	MD	209	10	
學			23a. Part1. Enter the disease, or shock, or heart failure. List	complications t	hat caused	the death	h. Do not ente	er the mode	e of dying	g, such as cardiac	or respiratory	arrest,			proximate erval Between	
Physi	ician		Immediate Cause (Final				ic Cora	olouns	CULI	or disease	is.			Or	nset and Death	
	dical		disease or condition resulting in death)	a	e to (or as											
Exan	niner		Control of the tipe of a distance	h												
V. T.	=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Du	6 10 (ur as	đ cu is o y	uanca vij.							1		
cutec	trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	. c										-		-
Ö, S	urial-	Ë	resulting in death) cast	Du	e to (or as a	a conseq	uence or):									
ate be e	pnysician and s the burial-transit	dicai		d										+		
death certificate be executed	attending p	/Me	IF FEMALE:	23c If ves	s, outcome	of pregna	ancy					2	3d. Date of	dalivery		
BOX	for us	lan	23b. Was decedent pregnant in the past 12 months?	101	ive birth Pregnant at	2 Feta	iloloeath 3□	Ectopic pro					Month	Da	y Year	
e g	ched	Physiclan/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Joknown			2 0 11/01 (0/21								
ords, P.O	been signed by the atte should be detached for	h h	Part It. Other significant conditi	ons contributing	to death bi	ut not res	ulting in the u	nderlying ca	ause give	en in Part I.	23e. Dio	l tobacco us	se contribute	to the c	ause of death?	
S D I	ng sign	d by									1 [Yes 2]No 3	Probably	y 4 Dunknov	٧n
VITAI RECORDS, sician: The law requires t	shou	Completed									24a. We		24b. Were	autopsy	findings availab	ole
The law	page 2	m C									aut per 1 🗆 Yes	opsy formed? 2 No	prior death 1 🗌 Y	? _	etion of cause o	r
<u>a</u> :	certificate rector, pag	C	25. Was case referred to medical							26. Place of Dea				03 24	2 140	
	is certific director.	0 8	examiner? 1⊠Yes 2 □ No	Hospital	1 Inpatie	ent 2 🗆	ER/Outpatier	nt 3 DO	Othe	er: 4 🗆 Nursing H	lome 5 Re	sidence 6	Other (S	pecify)		
DIVISION OF I or Attending Phy after death.		n: T	27. Manner of Death		Date of Inju	ry v Year)	28b. Time or Injury	f 2	8c. Injury	at	28d. Describ	e how injury	occurred			
IO ath.	it All	atio	2 1 1000000000	igation				М		Yes 2 □No						
VIS r Atte	irector: After I n by the funera	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 200. I	Place of Injudicing		ome, farm, str fy)	reet, factory	, office		28f. Location City or T	(Street and own, State)	i Number or	Rural Ro	oute Number,	
is aft	id le	Cer														
DIVISION C To the Hospital or Attending Pi within 24 hours after death.	ely fill	edicai	(Check-only 2 Medical	Examiner: On	the basis of	f examina	owledge, deat ation and/or in	h occurred vestigation,	at the tim , in my of	ne, date and place pinion, death occu	e, and due to thurred at the time	e cause(s) e, date and	and manner place, and (as state	d. e cause(s)	
the F	the I	Medi	one)	and	manner sta	ated.				e number			signed (Mo			
P Time	0 CO	~	29b. Signature and title of certifie	~					D121				ic 13, 2			
. /	-		, 000			last /**	- 02c) /* -	Driet)						-		
14			30. Name and address of person	who completed	cause of d	ieain (iter	15 Parts	ennu Cliure	BING	Hoosing	is , MK	o log	JC.			
, (*	Ch	ate			32. Registr	ar's Signa	ature	-01000		1,00						
· F	ىن Regist		31. Date filed (Month Day, Year APR 2 1	2004	iendone	-	Gos	Ser .								

		State of Marylar	nd / Department of Health and Certificate of Death	Mental Hygiene
	Physicia	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year 3. Time of Death
	/Medica	WILLIAM 1716	(AR I)	04 18 04 1:30 AM
N.	Examine	Cherry Lane Nursing Center	Laurel	and a startly of Booth
	Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		8. Date of Birth 9. Birtholece /State or Foreign
	end M	Usuel Residence of Decedent 10a. Stete 10b. County 10c. Ci	ity, Town or Location	10d. Inside City Limits
	Maryler a-f show	Maryland Prince George's	Laure1	1 ☐ Yes 2 No
	with the Maryler or 28s-f show	Maryland Prince George's 10e. Street end Number 2001 Champy Lane	10f. Zip Code	10g. Citizen of What Country?
	leeth w	9001 Cherry Lane 11. Marital Status 12. Was Decedent Ever in U Armed Forces? 1 □ Never Married 2 ☑ Merried 1 ☑ Yes 2 □ No	20708	United States Specify Yes or No- 14. Race - American Indian,
020	urs e	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1951	If Yes, specify Cuban, Mexican, Puer	Black, White, etc. Specify: Black
Maryland 21215-0020	"naturei"	15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of wo	16b. Kind of Business/Industry
212		Elementery/Secondary (0-12) College (1-4or 5+)	Security Personel	Private Company
bu	al Hygi	17. Father's Neme (First, Middle, Lest)		me (First, Middle, Maiden Sumame)
yla	2 should be filed within and Mantal Hygiene. is marked other than aumatic event, the Mantal Control of the Man		(Unknown) Genev	DIIII
Mai		19a. Informant's Name/Relationship (Type, Print) Ethel Callahan/ Daughter	19b. Mailing Address (Street and Number or Ri 6607 Grafton St., For	urel Route Number, City or Town, State, Zip Code) restville, MD 20747
Jre,	s 1 and 2 of Haalth item 27 i	20a. Method of Disposition 20b. F	4 7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Date 20c. Location - City or Town, State April,
Baltimore,	Pages ment of I	1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	sapeake Crematory Inc.	20,2004 Beltsville, MD
Ball	permit. Pages 1 and Department of Haalth important: if Item 27 any injury or other to once.	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Rapp Funeral and C 382 933 Gist Ave., Sil	remation Services
		23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	h. Do not enter the mode of dying, such as cardiac	c or respiratory arrest, Approximate Interval Between
and the second	Physician /Medical	Immediate Cause (Final		Onset and Death
1	Examiner	Immediate Cause (Final disease or condition resulting in death) a. Output Due to (output Due to (output	GES (GICEY)	
,-	sit ed	a b.		
90,	icate be executed physician end s the buriel-transit		л do a солоециелов of).	
68760,	tificate be ig physicis es the bu	resulting in death) Last Due to (or	r as a consequence of):	
Box	that the daath certifined by the attending detached for use es	d		
	he daz	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?
s, P.O	as that I	Derbetes Mellitin	type 2.	1 Yes 2 No 3 Probably 4 Unknown
of Vital Records,	aw requir		<i>Ot</i> y	24a. Was en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth?
<u>E</u>				1 ☐ Yes 2 █ No 1 ☐ Yes 2 ☐ No
VII	on	examiner?	Other	th (Check only one)
	al or Attending Physics after death. I Director: After this od in by the funeral di	To impatient 201	ER/Outpatient 3 DOA Street 4 Nursing H 28b. Time of Injury Work? M 1 Yes 2 No	ome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred
Division	Hospital or Attending P 24 hours after death. Funeral Director: After t stely filled in by the funeral or the funeral Certification.	3 Suicide 6 Could not be determined 28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	Hospiu 24 hours Funera tely fille	29a. Certifier (Check only one) Certifying Physician: To the best of my know the basis of examination and manner stated.	wledge, death occurred at the time, date and place, ion and/or investigation, in my opinion, death occur	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)
	within 2 To the	29b. Signature and title of benifier	29c. License number	29d. Date signed (Month, Dey, Year)
	nx1	30. Neme end address of person who completed cause of death (Item	1230) (Type Print)	17/04.
	State	31. Dete filed (Month, Day, Year) 32. Registrar's Signat	201 Greenhelt Rd, Suit	0 U-15, Golloge PK, MI) 20140
	Registrar	APR 2 1 2004 Anna	& frances &	

DHMH 16 Rsv 6/95

		•	For State Registrar	State of M	laryland / [Department Certificate	t of H	ealth a Death	and Me	ental Hygie	ene 20	0 4	120	147
	D1		1. Decedent's Name (First, Mide	die, Last)					2	2. Date of Death Month	Day Y	/ear	. Time of D	eath
	Physicia /Medic		Virginia	Emily Di	Lamond				A				3:11	рМ
	Examin		4a. Fecility Name (If not instituti		•	4b. City,	Town, or	Location o	of Death	:	4c. County of	Death		-
			Anne Arundel				napo				Anne A			
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last bir	thday) If Under Yrs. Months	1 Year Days	Hours 1	Min.	Date of Birth (Month, Day, Y	(ear)	 Birthplace Country) 		Foreign
	Director		212-30-4968 Usual Residence of Decedent		87	115.			J	an. 23,	1917	Virgi	nia	
	and		10a. State 10b. Count	ty	10c. City, Town	n or Location						10d.	Inside City	Limits
	Many	ō	MD Anne	Arundel	Anna	apolis,						;	XX Yes	2 🗌 No
	28a	rec	10e. Street and Number		111110	10f. Zip	Code			100	. Citizen of Wh	at Country?	,	
	38 o	Funeral Director	47 McPherson I	Road			214	401			USA			
	ma 2	ner	11. Marital Status	12. Was Decedent		13. Was Deced	ent of His	spanic Orig	gin? (Speci	fy Yes or No-	14. Race	American I		
9	after or ite	F	1 Never Married 2 Ma	Armed Forces 1 Yes 30		1 Yes 2		Specify:		can, etc.)		White, etc.		
21215-0036	within 72 hours after death with the Maryland ene. Than 'natural', or itema 23a or 28a-f show he Madical Evandret must be invitited at	d by	XXWidowed 4 ☐ Divorce	Year or Dates:		1		opouny.			Зреспу:	WILLE		
5	72 h	Completed		ent's Education lest grade completed)	16a.	Decedent's Usua (Give kind of wor life. DO NOT us	l Occupa k done d	tion <i>(uring most</i>	t of working	16	b. Kind of Busi	ness/Industi	ry	
<u>5</u>	han ne.	ш	Elementary/Secondary (0-12)	College (1-4or			e retirea)	,						
22	lled y		6 17. Father's Name (First, Middle	e. Last)	HC	omemaker		18 Mothe	ar's Name /	First, Middle, Ma	Own H			
ano	d be	Be C	James Leslie								,			
7	thoul d Me mark mati	ဥ	19a. Informant's Name/Relation		19b	. Mailing Address	(Street a			ay Baxte		ate. Zin Cou	de)	
<u>≅</u>	ith ar ith ar 27 is trau		Edwin Diamono			592 Nativ				•				
ē,	Hea Hea Hea Hea Hea Hea Hea Hea Hea Hea		20a. Method of Disposition	. (3.3.1)	20b. Place of	f Disposition (Namery, crematory or of	ie of	1	Dat		c. Location - C			
ê E	Page ent of the string ry or		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	n 3 □Removal from State (Specify)	9	cest Ceme		.	/20/2	004 A1	nnapoli	e. MD		
altimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Butterly, or itema 23a or 28a-1 show important: If tem 27 is marked other than "natural; or itema 23a or 28a-1 show any injury or other traumatic event, the Medical Exertered rust be a shifted at once.		21. Signature of Funeral Service		-24	22. Name and	d Addres	s of Facility	v			3 , 111		
ä	Deparition of the policy of th		172- 4.	Ofm						ome, P.A		21/01	1	//
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that cause	ed the death. Do r	not enter the mode	of dying	g, such as	cardiac or i	respiratory arrest		Api	proximate erval Betwe	een
F	hysician		Immediate Cause (Final disease or condition	\mathcal{D}									set and De	
	/Medical		resulting in death)		s a consequence							10	1	/
	Examiner		Sequentially list conditions.	b										
	p #	inei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or night)	Due to (or as	s a consequence	of):								
	eecute and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or a)	s a consequence	of)·							·	
8760,	death certificate be executed e attending physician and id for use as the burial-transit					,-								
687	icate phys s the	Physician/Medical		d.										
×	certific nding p	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy						23d. Date	of delivery		
Вох	that the death certifi ed by the attending detached for use as	ciar	in the past 12 months?	4☐Pregnant a	2 Fetal death at time of death	3 □Ectopic pre 5 □ Other (spe					Month		Ye Ye	ar
		hys	9 Unknown	9□ Unknown										
	w requires that s been signed b should be det	ру Р	Part II. Other significant condi	tions contributing to death	but not resulting in	n the underlying ca	ause give	n in Part I.		23e. Did tobac	cco use contrib	ute to the ca	ause of dea	ath?
ğ	en sig		Congest	ne heart	t tuil	ura				1 🗆 Yes	2 □ No 3	Probably	4 🗖	known
Vital Records,	4 2 2	Completed	/							24a. Was an autopsy		re autopsy for to comple		
œ .	The The page	mo;								performe	d? dea	ath? Yes 2		130 01
ita	Physician: The this certificate ral director, pag	Be (25. Was case referred to medic examiner?	al				26. Place	of Death /	Check only one)				
of V	Physic this ce al dire	2	1 ☐ Yes 2 No		ient 2 ER/Ou		_	4 🗀 1401	rsing Home	5 Residence	e 6 Other	(Specify)		
	ding Pl	ë.	27. Manner of Death 1 ★ Natural 5 □ Pend	28a. ate o nj (Month, D	iury 28b. 1 a <i>y Ye</i> ar) I	Time of 28 njury	8c. Injury Work	at ?	28	d. Describe how	injury occurred			
sio	Attending r death. ector: After by the fune	cati	2 Accident inves	stigation d not be		М		/es 2□N						
-	l or Attendate after death Director;	Certification;	4 Homicide deter	mined 288. Place of Ir	njury - At home, ta atc. <i>(Specify)</i>	rm, street, factory	, office		28	f. Location (Stree City or Town, S		or Hural Ho	ute Numbe	r,
_	pital Durs a eral I	Ö	29a. Certifier 1 ☐ Certify	ring Physician: To the bes	t of my knowledge	death occurred	at the tim	e date and	d place, and	d due to the caus	co(e) and mann	or as statos	4	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certific completely filled in by the funeral director.	edicai	(Check only 2 Medice one)	el Examiner: On the basis	of examination an	d/or investigation,	in my op	inion, deat	th occurred	at the time, date	and place, and	i due to the	cause(s)	
	vithin To th	№	29b. Signature and title of certif	ier		29c	. License	number		29d	. Date signed (Month, Dey,	Year)	
,	(> Ralt	No term			D	248	-04		4/16/	2004	/	
	X		30. Name and address of person	n who completed cause of	death (Item 23a)	(Type, Print)		<i>P B</i>			, -,-	- 6		-
			Robert	T Pet	erson	MID		AM	-me	- /	4/16/-	clis	Me	-//
	Sta		31. Date filed (Month, Day, Yea		trar's Signature	. /					0			1
	Registr	ar	APR 2 1	2004 2004	~ p	space	Kal	,						

			State of 1- State Amend Item#26, per 1	of Maryland / De Dr, G830,4/ළ	partment of F chilicateson	lealth and M Death	ental Hygien Reg. N		12068
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Death	ay Year	3. Time of Death
	/Medi Examir	cal	MARY JA 4a. Facility Name (If not institution, give street and num	ANE DULI		r Location of Death		c. County of Death	10:04 P ^M
			7724 FORD DRIVE			sadena		Anne	Arundel
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F	7. Age (In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Year		lace (State or Foreign try)
	ъ		Usual Residence of Decedent				August 8,1		<u>isylvania</u>
	Aarylau I ehow	ō	10a. State 10b. County	10c. City, Town o				10	0d. Inside City Limits 1 ☐ Yes 2 No
	r 28a-	Director	Maryland Anne Arundel 10e. Street and Number	rasa	dena 10f. Zip Code		10g. C	itizen of What Coun	try?
	23a o	ra D	7724 Ford Drive			21122		U.S.A.	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or iteme 23a or 28a-f show any injury or other traumatic event. I'm Medical Examinar must be tradified at ance.	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Dec. Armed Fc	2 Mo ve No	13. Was Decedent of H if Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Spec an, Mexican, Puerto F Specify:	ify Yes or No- ican, etc.)	14. Race - America Black, White, & Specify: Whi	etc.
2-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	(G	ecedent's Usual Occup	during most of workin	16b. I	Kind of Business/Ind	ustry
Maryland 21215-0036	within lene. than	Completed	Elementary/Secondary (0-12) College (1	- lif	fe. DO NOT use retired Homemaker	1)		Home	
nd 2	al Hygi other vent.	BeC	17. Father's Name (First, Middle, Last)		Homemaker	18. Mother's Name	First, Middle, Maide		
yla	ould by Ment	2	Ralph Mansfield			Anna S			
Ma	ulth and 2 sl		19a. Informant's Name/Relationship (Type, Print) Barbara Trohanowsky (Da	+	ailing Address (Street a				
altimore,	es 1 a of Hea if item or otha		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from	20b. Place of Di	sposition (Name of crematory or other place	Da Da		ocation - City or Tov	wn, State
ij	t. Pag rtment rtant: I		* 4 □ Donation 5 □ Other (Specify)	_ \	side Crema		-04 Dav	idsville.	nsylvania
Ba	Depa Impo any i	Ų,	21. Signature of Funeral Service Licensee	mull)	22. Name and Address McCully-Po 3204 Mounts	ss of Facility 1yniak Fur	eral Home	P.A.	21122
4			23. Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e	aused the death. Do not	enter the mode of dying	g, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	tarkable.	small con	11 long C	ncer	1	Onset and Death
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	P #	ner	Sequentially list conditions, if any leading to ammediate cause. Enter Underlying Cause (Disease or injury	or as a consequence of):					
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68760,	icate be executed physicien and s the burial-transit	edical E	d						
_	ertifica ding ph		IF FEMALE:						
.O. Box	the death certifiy the attending ached for use as	Physician/M	in the past 12 months?	ant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of deliver Month	y Day Year
Records, P.	The law requires that the death certificate be executed te has been signed by the attending physicien and tage 2 should be delached for use as the burial-transit	by	Part II. Other significant conditions contributing to de	eath but not resulting in the	e underlying cause give	en in Part I.		use contribute to the	
		Completed					24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	prior to com death?	sy findings available pletion of cause of
Viital	sician: Th certificate lirector, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	2 ED/0.4-	tiont 3 DOA Othe	26. Place of Death (THE CASE OF THE PARTY OF THE PA		-
Division of	ding Phys h. After this funeral dii	i —	27. Manner of Death 28a. Date of	npatient 2 ER/Outpat of Injury 28b. Time h, Day Year) Injur	of 28c. Injury	4 Nursing Home	esidence d. Describe how inju		
SIO	Attendir death. ctor: Af y the fur	catlc	2 Accident investigation		M 1 🗆 Y	res 2 □ No			
Σ	reira	Certification:	determined 286. Place	of Injury - At home, farm, ng, etc. (Specify)	street, factory, office	28	f. Location (Street ar City or Town, State	nd Number or Rural : a)	Route Number,
	To the Hospital of within 24 hours at To the Funaral D completely filled in	Medical (29a. Certifier (Check only one) 12 Certifying Physician: To the 2 Medical Examiner: On the ba and mann	asis of examination and/or	eath occurred at the tim investigation, in my op	e, date and place, an inion, death occurred	d due to the cause(s at the time, date and) and manner as stated place, and due to the	ted. he cause(s)
	To T Com	Σ	29b. Signature and title of certifier		29c. License		29d. Da	te signed (Month, De	ey, Year)
	10		30. Name and address of person who completed cause	e of death (Item 23a) (Tur	O L 2		Mari	11 69, 20	164
	Ψ		Aron Derkman 30	01 South A	Lonaer St	reet Sal	Homes Ma	y and 21	225
	Sta Registr	346		egistrar's Signature	books		,		

		1- For State of Registrar	Maryland / Depa Ce	artment of H	lealth and N Death	Mental Hygie	ne2004	12049
		Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
Physic		Walter G		Dabrows	ski		Day Year .9 2004	6.204 M
/Med Exami		4a. Facility Name (If not institution, give street and numb	per)		r Location of Death		4c. County of Death	6;30A
		1311 Apt. H. Scotts Da	le Dr.	BelAir	-		Harford	
Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)			8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign
Director		232-26-1330 NDM 2DF	81 Yrs.	World's Days	Hours Will.	June 21		yland
D 3		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ogation				10d. Inside City Limits
Aanyla r sho	5			Joanon				1 ☐ Yes 2 ☐ No
the A	Director	Maryland Harford 10e. Street and Number	BelAir_	10f. Zip Code		100	Citizen of What Cou	X
with a		1311 Apt. H. Scotts Dal	la De	·		TOG.		,
leath	era	11. Marital Status 12. Was Decede		21015 Was Decedent of H		acify Yes or No-	U.S.A	
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene, is marked other than "naturel", or items 23a or 28a-f show eumatic event, the Modeal Examiner must be notified at	by Funeral	Amed Force 1 Never Married 2 Married 1 Yes, Give 3 Widowed 4 Divorced Year or Date	es? ETNo		lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, White	
2 hou	fed	15. Decedent's Education	16a. Dece	dent's Usual Occup	ation	16b	. Kind of Business/Ir	ndustry
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ZTZ	E	3		eral Dire	ctor	F	uneral Ho	me
Ind 2 be filed ntal Hygi nd other	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Meio		
arylar should b nd Ments n marked	2	Adam F. D	abrowski		Anna		Pied	zak
Maryland d 2 should be flie th and Mental Hy t7 is marked oth treumatic event		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	and Number or Rura	al Route Number, Cit		
5 2 € 5 5		Sue Dabrowski (Wife)	1311		Scotts	dale Dr. I	BelAir , N	Md. 21015
n • • • •		20a. Method of Disposition ty⊟ Burial 2 □ Cremation 3 □ Removal from Sta	20b. Place of Dispo cemetery, crer	sition (Name of matory or other plac	Apr	Date 20c.	Location - City or T	own, State
Pages Pages ment of ent: If it		* 4 □ Donation 5 □ Other (Specify)		ary Cemet	tery 21,20		ındalk, Ma	rvland
Baltimore, permit. Pages 1 ar Department of Hea Importent: if item; any injury or other once.		21. Signature of Funeral Service Licensee	α	Name and Address W. Dahros	rales Chas	manalat II	1 77	and the state of t
- 40280		23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	the.	1005 Dun	dalk Ave	Balto., M	d. 21224	
		shock, or heart failure. List only one capse on eac	h line.	er the mode of dying	g, such as cardiac o	or respiratory arrest,	1	Approximate Interval Between Onset and Death
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	ē	Sequentially list conditions. If any, leading to immediate b. Due to (or	as a consequence of):					
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executed an and rial-transit	Exa		as a consequence of):					
— • • • • • • • • • • • • • • • • • • •	dical	d.						
		ICCEMA C.						
BOX 6 eath certifications attending 1	an/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outco		Ectopic pregnancy		,	23d. Date of delive	,
.C. BOX 6 the death certifi y the attending tched for use as	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnan 9 ☐ Unknown 9 ☐ Unknown		Other (specify)			Month	Day Year
that the de		Part II. Other significant conditions contributing to deat	h but not resulting in the u	nderhina cause awa	on in Part I	23a Did tohaco	o use contribute to the	he cause of death?
Hecords, P The law requires that the has been signed be determined.	ted by					1 Tyes		A.
4eC	Completed					24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
	So					performed? 1 ☐ Yes 2 🔀	? death?	25 No
VITAL Sicien: T certificat rector, pa	Be	25. Was case referred to medical examiner?		0.1	26. Place of Death	(Check only one)		
OT Physi	۴	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inp			4 Nursing nor	ne 5 Residence		y)
On On Oil ding Ph. After the funeral	ion	A Martinal S Perioding	njury 28b. Time of Day Year) Injury	Work		28d. Describe how in	jury occurred	
ISIC death death stor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be 388 Place of	Injury - At home, farm, stre		Yes 2 □No	28f. Location (Street	and Number or Dum	J. Pauda Alumbar
DIVISION tor Attending after death. Director: Afte	Certification:	4 Homicide determined 286. Place of building.	etc. (Specify)	eet, ractory, onice		City or Town, Sta		i noute Number,
UNISION OT VITA To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner and manner	s of examination and/or inv	n occurred at the tim vestigation, in my op	e, date and place, a pinion, death occurre	and due to the cause and at the time, date a	(s) and manner as si nd place, and due to	rated. the cause(s)
To the within To the Comple	Me	29b. Signature and title of certifier		29c. License	number	29d. D	Date signed (Month,	Dey, Year)
/		Dans 5 Du		03	2255	Ar	oril 19,20	004
4		30. Name and address of person who completed cause of	of death (Item 23a) (Type,	Print)	\			
0		Day, D 5 D UND	675 W. N	MEHNA	4, Be	lair n	10	
St Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 1 2004	Allers &	fores !	er.			

			1- For State of Maryland / Department of Health Certificate of Dear			ene	anı.	10	0.5
	Physic		1. Decedent's Name (First, Middle, Last) Richard B. Dockins	2. Da	ite of Death	Day	Year	3. Time of	Death AM
dec	/Medi Examir		4a. Facility Name (If not institution, give street and number) Cranberry Cottage's Assisted Living Glen Burni	ion of Death	oril.	4c. County Ar.	of Death	rundel	
	Funeral Director		5. Social Security Number 200-05-5234 Usual Residence of Decedent 6. Sex 1 M 2 F 84 7. Age (In yrs. last birthday) Wonths Days Hour	irs Min. (Mi	te of Birth onth, Day,			ace (State of try) ISy1va	
	a-f show	ctor	10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Lansdowne				10	Xd. Inside Cit	•
	th with the 23a or 28	ai Director	10e. Street and Number 10f. Zip Code 112 Hazel Ave. 21227		10	g. Citizen of V		ry?	
920	72 hours after death with the Maryland natural; or Itema 23a or 28a-f show dical Existing at Intest by notified at	by Funeral	11. Marital Status 1		es or No- etc.)	14. Race	- America k, White, e	itc.	
Maryland 21215-0036	within ane. than	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 16a. Decedent's Usual Occupation (Give kind of work done during matrix) life. DO NOT use retired) Painter	most of working		5b. Kind of Bu			
and ?	be filed tal Hyg d othe	Be	17. Father's Name (First, Middle, Last) 18. Mo	other's Name (First,	Middle, Ma		θ)		
Maryi	s 1 and 2 should be in Health and Mental I itam 27 is marked of other traumatic even	2	19a. Informant's Name/Relationship (Type, Print) Alverta L. Dockins, daughter 112 Hazel Ave.		Number, (City or Town,	State, Zip (nknow
Baltimore,	Pages 1 and 2 nent of Health int: If itam 27 iny or other tra		20a. Method of Disposition XD Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial	Date	20	c. Location -	City or Tow		
Balt	permit. Pages Department of I Important: If its any injury or of		21. Signature of Funarel Service Licensee 22. Name and Address of Fune: Ambrose Fune: 2719 Hammond:	acility ral Home	of La	nsdown	e		1227
	death certificate be executed Washington and tor use as the buriat-transit	dicai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Carl	atory arres		1	Approximate Interval Between Manager Interval Between Manager Interval Between Interval Bet	veen
. DOX	death certif e attending id for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			23d. Date Mon	of delivery		ear
rds, r.o	es De de	ed by Ph	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Par	art I. 23	e. Did tobac	cco use contril		cause of de	
L Kec	3 □ 0	Completed		1		d? pr	or to comp eath?	sy findings av	vailable use of
1011 01 411	Attending Physician: The la r death. ector: After this certificate has by the funeral director, page 2	ation: To Be	OAGIIIII OI !		Residenc	e 6 Dether	(Specify)	fred	liff
5	Dir.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)	28f. Loc. City	ation (Stree or Town, S	et and Number State)	r or Rurai F	loute Numbe	Ð <i>Γ</i> ,
	the Hospital in 24 hours a the Funeral i pletely filled	edical	29a. Certifier (Check only one) 1. Artifying Physician: To the best of my knowledge, death occurred at the time, date a control of my knowledge, death occurred at the control occurred at	and place, and due death occurred at the	to the caus time, date	e(s) and man and place, ar	ner as state and due to th	∍d. ne cause(s)	
	To the I within 2. To the Complet	Σ	29b. Signature and title of certifier 29c. License number 02-00		29d.	Date signed	(Month, Da	y, Year)	
	V		30. Name and address of person who completed cause at eath (Item 23a) (Type, Print) Ellioff full sty My 31. Date filed (Month, Day, Year) 32. Registrar's Signature	hur C	Mon	Burni	E, 14.	disco	26/
	Sta Registr	-	APR 2 1 2004 Sensor & Source	-					/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 12051 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 15 **Physician** EASTERDAY APRIL 2004 5.00p WILLIAM WILLARD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 8. Date of Birth Sept. 2, 1935 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1**∑**M 2□ F Days Hours 68 Mary land 217-30-5599 Director Usual Residence of Deceden Manyland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Itema 23a or 28a-f show traumatic event, the Modified at Maryland Frederick Frederick 1∰Yes 2 No Directo death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21701 612 Trail Ave. Completed by Funeral 12. Was Decedent Ever in U.S. Amped Forces? 1 ∑Yes 2 □ No If Yes, Give 1960–1964 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry
Iron and Steel 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat any injury or other traumatic event, the Medica once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Manufacturing Payroll Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie Bover Willard William Easterday 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Poplar Street, Myersville, Maryland Michael D. Smith, PR 20a. Method of Disposition
1 □ Burial 2 X Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State April 17, 2004 Smithsburg, MD Smithsburg Crematory ^ 4 ☐ Donation 5 ☐ Other (Specify) 22. Jume and Address of Edisford FA Funeral Home Reeney and Edisford FA Funeral Home 106 East Church St., Frederick, MD 21701 21. Signature of Funeral Service Licensee Richard E. M00255 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE RENAL FAILURE Physician 5 Druge disease or condition resulting in death) /Medical Examiner Cardiomyopully Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last nding physician and use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 1 Live birth 3 Ectopic pregnancy in the past 12 months? Year Month Day signed by the at id be detached for 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ٩ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident after death 6 Could not be determined 3 🗌 Suicide Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D43091 P 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fralluly . HM House Are,

State Registrar

241D1

SAEED

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MO

80%

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2001 1 Decedent's Name (First Middle Last 2 Date of Deeth 4b, City, Town, or Location of Death Fecility Name (If not institution, give street and number) 4c. County of Deeth CATONSVILLE NURSING If Under 24 Hrs. 8. If Under 1 Year (In yrs last birthday) Yrs. Birthplace (State or Foreign Days 09.7706 Usuel Residence of Decedent 10b. County 10c. City, Toy n or Location 10d. Inside City Limits MD SAUTIMORE 1 Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 22 ND 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cultan, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 1 1 No Specify: 3 Widowed 4 Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) MAINTENANC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4.22.0400Was Mills, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses BACTI MORE NOTIONAL PIKE, BACTO, MOZIZES 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1SEASE Due to (or es a consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy 1 Yes 2 M 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1 Yes Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed

Physician /Medical

Examiner

Director

Funeral

à

Completed

Be

10a. State

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Pages 1 end 2 should be filed within 72 hours after death with the Marylend nent of Health and Mental Hygiene.

f Health and Mental Hygier tem 27 is marked other th other traumatic event, the

Ξ δ

Saltimore, Maryland 21215-0020

Physician/Medical Examiner δ filled in by the funeral director, page 2 should be Be Completed Medicai Certification: To To the Hospital or Attendir within 24 hours efter death. To the Funeral Director: Af

After this certificate has been

Division of Vital Records, P.O. Box 68760

Registrar

State

31. Date filed (Month, Day, Year)

TASNEEM

29b. Signature and title of certifier

27. Mann of Deeth

1 Naturel

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

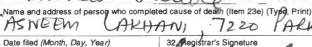
APR 2 1 2004

sueen

5 Pending

investigation

6 Could not be determined



28e. Date of Injury (Month, Day Year)

28591

28c. Injury at Work?

바스 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

120/00

29d. Date signed (Month. Dav. Year)

DHMH 16 Rev 6/95

28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004

12053 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MELODYE FLEIDS 6:05 D. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA JOSEPH BALTIMORE RMCHIE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, DQ-15-5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 201 F 32 212-90-0138 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits A shows and Members Hygiene. I have seen that the marked other than "netural", or items 23a or 28a-1 ahow is marked other than "netural", or items 23a or 28a-1 ahow raumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Completed by Funeral Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? LANVALE STREET 21216 USA 2541 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Never Married 2 Married 5-0036 1 ☐ Yes 2 ☑ No Specify. Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2121 College (1-4or 5+) Z YRS Elementary/Secondary (0-12) SALES ASSOCIATE RETAIL 12/14 GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MELVINNIA THOMPSON DONALD FIELDS other traumatic ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ST. permit. Pages 1 and 2:
Department of Health ar
Important: if item 27 Is
any injury or other trau RENAE THOMPSON BALTO. W. LANVALE MO Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State DULANEY VALLEY ¹ 4 □ Donation 5 □ Other (Specify) IOWSON 21. Signature of Funeral Service Licens VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATU PIKE, BALTO. MO 2 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or near failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. Physician/Medicai the as IF FEMALE for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 🗆 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? (es 2/10 No certificate 1 Yes Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 DOther (Specify) TO DICC 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending To the Husperson within 24 hours after death.

To the Funerel Director: Alt 2 🗌 No investigation 1 TYes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month. Day, Year) Hausin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSEDU 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 1 2004

Registrar

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MELODYE

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Tr. 1	J. IIDN		For State Registrar		State of I	Marylan	d / Depa <i>Cei</i>	artment c rtificate	of H	ealth a D <i>eath</i>	and M	lental Hy	giene Reg. No	200)4	12054
	Physici	an		e (First, Middle, Las				-				2. Date of De Month		ıv '	Year	3. Time of Death
	/Media		Hel			Fiske	r					APRIL	18	3, 200	04	2005 P M
	Examir	er		If not institution, give OSS HOSPI'		ər)		4b. City, Tov		Location of SPR.			40	. County of		RY
	Funeral Director		5. Social Security N	-6337 1	9x □ M 2√√2 F	Age (In yrs. 82	last birthday) Yrs.	If Under 1 Y Months Da	'ear ays	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 10/17	th ly, Year / 19	21 M	Cour	place (State or Foreign office) Tand
	and **		Usual Residence o 10a. State	10b. County		10c. Cit	v. Town or Lo	cation							1	0d. Inside City Limits
	Manyll f eho	ō	MD	Montgor	nerv	Si	lver	Sprin	ന							1 TYPes 2 □ No
	28a-	rect	10e. Street and Nu			01	1701	10f. Zip Co	_				10g. Cit	tizen of Wh	nat Cour	ntry?
	3a ou	I DI	321 Uni	versity	Blvrd.			2	090	01				.S.A		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show with jujury or other treumatic event, the Medical Examinar roual be notified at Ance.	by Funeral Director	11. Marital Status 1 Never Marr 3 Widowed	ried 2 Married 4 🖔 Divorced	12. Was Decede Amed Force 1 Yes 2 If Yes, Give Year or Date	s? ⊠No		Was Decedent f Yes, specify	Cubar	spanic Ori n, Mexican Specify:	gin? (Spi , Puerto	ecify Yes or No Rican, etc.)		14. Race Black, Specify:	, White,	
9	2 hou	ted		15. Decedent's Ed	ucation		16a. Dece	dent's Usual O	ccupa	tion		×.	16b. K	ind of Busi		
21215-0036	I within 7: iene. r than "n	Completed by	Elementary/Second 12th	ondary (0-12)	de completed) College (1-4c	or 5+)	life.	kind of work d DO NOT use re itual	etired)			ing	Se	1f		•
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	l and lealth im 27 her tu		Lance F		(Son)	20h B				Ave.		koma l				
Baltimore,	Pages 1 ment of H ent: If ite ury or ot	Commission	1 🗆 Burial 2	position ☐ Fremation 3 ☐ 5 ☐ Other (Specify		, c	emetery, crer	sition (Name of natory or other Le Par	r place)		0ate 0/200		Rive	,	
Balt	permit. Depart Import eny inj		21. Signature of Fu	uneral ervic Lice	7			. Name and A $321\ 14$			110	stin I W. Wæs	Roys	ster	Fur	neral Hom
			23a Part1. Enter t	ne disease, or compart failure. List only	ofications that caus	sed the death	. Do not ent	er the mode of	dying	, such as	cardiac o	or respiratory a	rest,	-DU 2		Approximate Interval Between
	Physician		Immediate Cause disease or condition	(Final	. N			juries								Onset and Death
	/Medical		resulting in death)		Due to (or	as a consequ	uence of):	<i>.</i>		-						
	Examiner	_	Sequentially list co	onditions,	b											
	ed str	lne	if any, leading to in cause. Enter Under Cause (Disease or	nmediate erlying	Due to (or a	as a consequ	dence of):									
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89					u.											
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	w requires that the death been signed by the atte should be detached for		Part II. Other signit	ficant conditions co	ontributing to death	but not resu	ulting in the ur	nderlying cause	e givei	n in Part I.						e cause of death?
Ö	v requ	etec										-				
al Records,	The lay ate has page 2	Completed										24a. Was autop perio 1 X Yes	rmed?	prid	or to con th? Yes	osy findings available inpletion of cause of 2 No
Vital	Physician: this certific ral director.	Be	25. Was case refer examiner?		Hospital:	156.7						(Check only o				
of	Fa F	. To	1 X Yes 2 ☐ 27. Manner of Deat	140	I □ Inpa		ER/Outpatien 28b. Time of		Injury			ne 5 Resid				
OU	Attending Ph r death. ector: After thi by the funeral	Certification:	1 Natural 2 Accident	5 Pending investigation	28a. Date of Ir (Month, I		Injury		Work'	es 2 101	î	driver of	an	notar b	1ehic	le that collide
Division	Atter r dea ector by the	ifica	3 ☐ Suicide 4 ☐ Homicide	6 Could not be	28e. Place of	Injury - At ho	me, farm, str		fice			28f. Location (S	treet an	d Number	or Rural	Route Number
Ö	s afte	Sert	4 Homicide		bullding,	etc. (Specify		ad			1	n front of t	m, State 1321	Silver	Timin	in versity Blud
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one)	1 Certifying Phy 2X Medical Exam	ysician: To the be iner: On the basis and manner	of examinat	wledge, death ion and/or inv	occurred at the	ne time my opi	, date and nion, deat	f place a	and due to the	alice/c)	and mann	er as sta	ated
	To the within 2 To the complet	Me	29b. Signature and	title of certifier	m.D	·		29c. Lid		number .M.E				e signed (I		· · · · · · · · · · · · · · · · · · ·
	2		30. Name and addr	ress of person who d		f death (Item	23a) (Type	Print)								
	8				mi				t,	Balt:	imor	e, Mary	land	1 2120	01	
	Sta	te	31. Date filed (Mon		32. Regis	strar's Signat	ure			ne.						
	Registr	ar	ΛPR	2 1 2004	Gener	, a	B	frait.	1	ŭ						

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryland / [Department of Certificate	of Health and M Of Death	lental Hygier Reg. 1		12055
	Physici		1. Decedent's Name (First, Middle, La Delphine Inc	si) dira Lucia Fomi	1150		2. Date of Death Month April 7.	Day Yeer	3. Time of Death 11:53 M
) T	/Medic Examir		4a. Fecility Name (If not institution, giv Holy Cross Hos	e street and number)	4b. City, Tox	m, or Location of Death Ver Spring		4c. County of Deet	th
	Funeral Director		Social Security Number 6. S	Sex 7. Age (In yrs. last bir	rthday) If Under 1 Y		8. Date of Birth (Month, Day, Ye March 6	Montgo 9. Birt 2004	thery tholece (State or Foreign buntry) Maryland
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Mont	gomery Silve		r e			10d. Inside City Limits 1
	with the	i Director	10e. Street and Number 14201 #31 Weep:	ing Willow Dr	10f. Zip Co	20906	10g.	Citizen of What Co	•
õ	n 72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show wilcal Examinat must be notified at	y Funeral	11. Marital Status 1 ⊠Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No	13. Was Decedent If Yes, specify	of Hispanic Origin? (Spe Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	nican Indian, e, etc.
215-0036	within 72 hours ene. than "naturel!, rie Mudical Exi	Completed by	3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	If Yes, Give Year or Dates: N / A ducation discompleted) College (1-4 or 5+)	. Decedent's Usual O (Give kind of work o life. DO NOT use n	ccupation	ng 16b.	B. Kind of Business/	1ack Industry
and 21	be filed tal Hygi d other event, I	Be	N/A 17. Father's Name (First, Middle, Last) William Fomus		N/A	1	(First, Middle, Maidle Ne Maill:		
Mary	s 1 and 2 should f Health and Men ltem 27 is marke other treumstic	To	19a. Informant's Name/Relationship (Sandrine A. Ma	Type, Print) illi -Mother 14	4201~#31				er Spring,
saitimore,	permit. Pages 1 a Department of He- Important: If Item any injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Contain 5 ☐ Other (Specification of the contain of	Removal from State cemeter		chool 04/1	4/2004		ton, DC
Ball	Depart Depart Import any inj		21. Signature of Funeral Service Lice	1988		ddress of Facility Λus $1 an us$ N .			neral Home 11
	Physician /Medical		23a. Part1. Enter the #Sease, or com shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	pilications that cause the death. Do one cause on each line. a. <u>Extreme Pre</u>	ematurity		r respiratory arrest,		Approximate Interval Between Onset and Death 32 Davs
	Examiner	Ji	Sequentially list conditions,	Due to (or as a consequence Severe Chro	onic Lung	g Disease			32 Days
۵ŋ,	eath certificate be executed attending physician and for use as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Renal Failu	ire				2 Days
04 68 / 6U	certificate be nding physicia use as the bur	/Medical	IF FEMALE:	23c. If yes, outcome of pregnancy					
	t the death or by the atten ached for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐Ectopic pregn 5 ☐ Other (specif			23d. Date of deli Month	very Day Year
ecords, r	w requires that the death cer been signed by the attendin should be detached for use	δ	Part II. Other significent conditions of	ontributing to death but not resulting in	n the underlying caus	given in Part I.		o use contribute to	the cause of death?
_	The lar ate has page 2	Completed					24a. Was an autopsy performed?	prior to o death?	topsy findings available completion of cause of 2 No
on or vital	Attending Physician: r death. ector: After this certific by the funeral director,	ion: To Be	25. Was case referred to medical examiner? 1 ☐ Yes	(Month, Day Year)	Time of 28c.		Check on one ne 5 Residence 8d. Describe how in		ify)
DIVISION	To the Hospital or Attending Phys within 2 Hours after death. To the Funeral Director: Atter this a completely filled in by the funeral directors.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined				28f. Location (Street City or Town, Sta		ral Route Number,
	the Hosp in 24 hou the Fune pletely fil	edical	29a. Certifier 1X Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowledge niner: On the basis of examination an and manner stated.	e, death occurred at the	e time, date and place, a ny opinion, death occurre	and due to the cause and at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To T Con	2	29b. Signature and title of certifier			ense number 055515	29d. C	Date signed (Month	n, Day, Year)
			Astol asylonia		(Type, Print) Forest G	len Rd. 3	Lygo 3	mns.	MD 20916
· ·	Sta Registr	- 1	31. Date filed (Month, Day, Year) APR 2 1 2004	32. Registrar's Signature	and			3	

		•	For State Registrar	State of Maryla	and / Department of I		lental Hygien	2001 10
	Physici		1. Decedent's Name (First, Middle, La	uline Fall			2. Date of Death Month Da	3. Time of Death
	/Medic	al -	4a. Facility Name (If not institution, give			or Location of Death	April 1	2004 0013 M
	Examir	er	Anne Arvivel	Medical Cent	Lor A	nnapolis		Anne Arendel
	Funeral Director		5. Social Security Number 6. S		s. last birthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year April 17,20	
	land bw		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Location			10d. Inside City Limits
	a-1 sh	ctor	Maryland Anne 1	trundel	Crofton			1 ☐ Yes 2 No
	h with the 23a or 28	al Director	10e. Street and Number	prone St.	10f. Zip Code	1114	10g. C	itizen of What Country? USA
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or itema 23a or 28a-1 show importent: If item 27 is marked other than "hatural", or itema 23a or 28a-1 show importent; If item 27 is marked in the latest of the analysis of the confined at the confined a	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ₩ No If Yes, Give Year or Dates:	U.S. 13. Was Decedent of If Yes, specify Cult		ecify Yes or No- Rican, etc.)	14. Race - American Indian, Bfack, White, etc. Specify: White
Maryland 21215-0036	thin 72 hou e. an "natural Medical E	Completed I	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	during most of work	ing 16b. H	Kind of Business/Industry
7	filed will Hygien other th		17. Father's Name (First, Middle, Lasi	3	N/A	18 Mother's Nam	e (First, Middle, Maide	N/A
lanc	Mental H Mental H arked ot atic ever	To Be		stopher Fa	llon			irie Deckman
Mary	nd 2 should Ith and Mer 27 is marke 17 raumatic		19a. Informant's Name/Relationship Sean Fallon	Type, Print)	19b. Mailing Address (Street			
	s 1 and of Health item 27 other tr		20a. Method of Disposition	20b	Place of Disposition (Name of cemetery, crematory or other place)			ocation - City or Town, State
altimore,	Pages ment of ent: If it		1 ☐ Burial 2 🏋 emation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		etro Crematory	4/21	1/2004 Bal	timore, MD
Balt	permit. Pages. Department of the importent: If its any injury or of once.		21. Signature of Funeral S	nsee	22. Name and Addr Hardest 12 Ridg	y Funeral	Home, P.A.	s, MD 21401
	ž.		23a. Part1. Enter the diseaser or con shock, or heart failure. List only	plications that caused the de	eath. Do not enter the mode of dy	ing, such as cardiac		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons	ne: Vvema. equence of):	turity.		7 minutes
	Pe is	lner	Sequentially list conditions, if any, leading to immediate cause. Enter or Jacking Cause (Disease or injury)	Due to (or as a cons	equence of):			
,092	icate be executed physician and s the burial-transit	Ical Examiner	that initiated events resulting in death) Last	c	equence of):			
.O. Box 68	death certif e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. ff yes, outcome of preg 1 □ Live birth 2 □ Fo 4 □ Pregnant at time of 9 □ Unknown	etaf death 3 Ectopic pregnan	су		23d. Date of delivery Month Day Year
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Records,	The law requires ate has been sign page 2 should be	Completed					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
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of V	1 × × ×	မ	1 ☐ Yes 2 Solo	Hospital: 1 Impatient 2 28a. Date of Injury	LI ENOUIDATION 3 DOA		ome 5 Residence	
ion	Attending F r death. sctor: After by the funera	atlon	27. Manner of Death 1 Satural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) on		ury at ork? ☐ Yes 2 ☐ No	28d. Describe how info	ury occurred
Division	를 들는 C	Certification:	3 Suicide 6 Could not 4 Homicide determined		t home, farm, street, factory, office acity))	28f. Location (Street a City or Town, Star	ind Number or Rural Route Number, te)
	ne Hospital of 24 hours at the Funerel Dietely filled i	edical	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best of my k miner: On the basis of exam and manner stated.	knowledge, death occurred at the ination and/or investigation, in my	time, date and place, opinion, death occur	and due to the cause(s red at the time, date an	s) and manner as stated. nd place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	////		nse number		ate signed (Month, Day, Year)
			MACHAIL	14/ac49	tem 23a) (Type Print)	5446	Up	11d. 2140/
		!	30. Name and address of person who	compreted cause of death (I	tern zsa) (Type, Print)	1 101-	1	11 22111
			Debia Hardy 31. Date filed (Month, Day, Year)	Calturight #32. Registrar's Sig		1 Fray,	Anna po lis	11102 21401

			1 - For State Registrar	State of Maryla		partment of I		nd Mental	Hygie Reg.	2011	4 1205
	Physici	an	1. Decedent's Name (First, Middle, Last	Marie Fall	0.5			2. Date Month	of Death	Day Year 17 2001	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give		ION	4b. City, Town, o	or Location of	Death Apr		4c. County of Dea	
	LAUITIII		Anne Arunda	1 Medical	Center	1	Annap.			_	Arundel
	Funeral Director		1017	7. Age (In yrs	s. last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hours		h, Day, Ye	9. Bi	ountry) Marylan d
	yland low		Usual Residence of Decedent 10a. State 10b. County	10c. C	city, Town or			,			10d. Inside City Limits
	Ba-fsh	ctor	Maryland Anne	Arundel	CL	ofton					1
	th with th	al Director	10e. Street and Number	ne St.		10f. Zip Code	1114		10g.	Citizen of What C	
920	72 hours after death with the Maryland neturel', or items 23s or 28ef show dited Franciscon in the recitives at	by Funeral	11. Marital Status 1 □ 40 ever Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in I Armed Forces? 1 Tes 2 December 1 If Yes, Give Year or Dates:	U.S. 13	Was Decedent of Hilf Yes, specify Cub	dispanic Originan, Mexican, I Specity:	n? (Specify Yes o Puerto Rican, etc	or No-	14. Race - Am Black, Whi	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f show styl highty or other traumatic event, the Medical Evatra included by profiled at ance.	Completed	15. Decedent's Edu (Specify only highest grad	cation de com <i>pleted)</i> College (1-4or 5+)	(Giv	edent's Usual Occup e kind of work done DO NOT use retire	during most o		16b.	Kind of Business	/Industry
Maryland 2	should be fited nd Mental Hygi marked other amatic event, I	To Be Co	17. Father's Name (First, Middle, Last) Sean Christ				Me		Ma	me D	eckman
	and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationship (Ty Sean Fallon/F	ather	1-	ling Address (Street					
Baltimore,	Pages 1 nent of Hi int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 Ø remation 3 ☐ R	Removal from State	Place of Disp cemetery, cr	position (Name of smatory or other place	· 1	Date	20c.	Location - City or	Town, State
ij	artmer ortant Injury		*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	1220		cematory 22. Name and Addre	-	21/2004	Ва	ltimore,	MD
ä	permit. Departrimports eny inju	5 3	13- 2.CL		1	Hardesty	/ Funer	al Home	P.A	is, MD 2	1.401
	Physician /Medical		23a. Party. Enter the disease, of complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)		· Pri	nter the mode of dyin	ig, such as ca	rdiac or respirato	ry arrest,		Approximate Interval Between Onset and Death
	Examiner	er	if any, leading to immediate	b. Due to (or as a consec	quence of):						
8760,	ate be executed nysician and he burial-transit	I Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consec	quence of);						
687	physicate by street of the branch of the bra	dical		1.							
P.O. Box (The law requires that the death certificate be executed the has been signed by the attending physician and wage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of o	al death 3	□Ectopic pregnancy □ Other (specify)				23d. Date of del Month	ivery Day Year
	uires that the de signed by the a d be detached f	þ	Part II. Other significant conditions con	ntributing to death but not res	sulting in the	underlying cause give	en in Part I.			4	the cause of death?
Records,	w require s been sign should b	lete						24a. V	-		
Vital Re		e Completed	25. Was case referred to medical					a p	utopsy erformed? s 2 3	prior to death?	topsy findings available completion of cause of
	Phyaician: r this certifica ral director, p	To B	examiner?	lospital: 1 Department 2	ER/Outpatie	nt 3 DOA Othe		Death (Check or		6 ☐ Other (Spec	ih.l
Division of	ing Afte une	ertification:	27. Manner of Death 1 Abatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work				ury occurred	uy)
Divis	7 2 2 6	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	fy) 			City or	Town, Sta	te)	ral Route Number,
	To the Hospital of within 24 hours at To the Funerel D completely filled in	edical	29a. Certifier Check only one) Certifying Physical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, deal ation and/or in	th occurred at the tim evestigation, in my op	ne, date and p pinion, death o	lace, and due to to occurred at the tin	the cause(ne, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To t To t	2	29b. Signature and title of certifier	when the		29c. License D354				ate signed (Month	
			30. Name and address of person the col	mpleted cause of death (Iter	п 23a) (Туре, 2003	Print) Medical	PK	wy An	naps	lis ind.	2144
, W	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	الع		1			

			1 - For State Registrar	State of M	aryland	-	artmen				Mental F		ie io.2 ()	n L	12050
			1. Decedent's Name (First, Middle,	Last)							2. Date of	Death			3. Time of Death
4	Physic /Medi		JOAQUIN VIRGILI	O FANJUL							APRIL	16,2	8 04	Year	12:55р м
	Exami		4a. Facility Name (If not institution,	•			4b. City,	Town, or	Location of	of Death		4	c. County	of Death	
			SHADY GROVE ADV					CKV1			·		ONTG	OMERY	
м	Funeral		5. Social Security Number 217–25–7949	6. Sex 7. A 1∭3 M 2☐ F	ge (In yrs. Ia: 41	st birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of (Month,	Day Yea	r)	9. Birthpl	lace (State or Foreign try)
	Director		Usual Residence of Decedent		41						Nov.	L/, L	962	Arge	ntina
	yland		10a. State 10b. County		10c. City,	Town or Lo	cation							10	0d. Inside City Limits
	e Ma	ctor	Maryland Montgo	mery	Gai	thers	burg								1 ☐ Yes 2X No
	or 28	Olre	10e. Street and Number				10f. Zip	Code				10g. C	itizen of	What Count	try?
	ath w	ra	9589 White Pill				20	0882				Uni	ited	State	es
	ter dea Itams	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces	?	13. \	Nas Deced f Yes, spec	lent of His	spanic Orig n, Mexican	gin? (Sp , Puerto	ecify Yes or Rican, etc.)	No-		e - America ck, White, e	
36	rs aft	by F	1 ☐ Never Married 2 X Marrie 3 ☐ Widowed 4 ☐ Divorced	od 1 □ Yes 2 📉 If Yes, Give Year or Dates:			1⊠ Yes 2	2□ No	Specify:	۸			Specif	/: TT .	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. dother than "netural", or Itams 23a or 28e-f show event, the Medical Executer must be rectified at	ed	15. Decedent's	Education		16a. Deced	lent's Usua	I Occupa	tion		ntine	16h	Kind of B	Whi usiness/Ind	
215	nin 72	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or		(Give	kind of wor DO NOT us	k done d	urina most	of work	ing	100.1	I Carlo Of D	3111033/1110	ustry
21	d withi giene. er than	No.	Bollonary, Sociality (6 12)	4	34)	Trucl	c Driv	ver				Pr	oduc	e	
pu	be filed tal Hygid d other evant, I	Be (17. Father's Name (First, Middle, L.	ast)					18. Mothe	r's Nam	e (First, Midd	lle, Maide	n Suman	ne)	
yla		2	Ricardo Fanjul						De	lia	Beatr	iz Vi	ctor	ia	
Maryland	2 should and N Is mail		19a. Informant's Name/Relationshi								al Route Nur				
6	is 1 and 2 should of Health and Meritam 27 Is marks other traumetic		Maria J. Fanjul 20a. Method of Disposition	/Sister	20h Blo	10500	Rock	kvil	le Pi	ke,	#1505	Roc	kvi1	le, M	D 20852
õ			1 🗆 Burial 2 🖾 Cremation 3		Mont	ce of Dispo netery, cren gomen natori	natory or ot	ne or ther place) A		Date L 20,	20c. L	_ocation -	City or Tov	wn, State
Baltimore,	it. Partmer rtant njury		' 4 □ Donation 5 □ Other (Special Sign 12 - Funeral Service Li		Cren					2004		Bet	hesd	a, Ma	ryland
Ba	permit. Page Department of Important: If any injury or		3 Carle	lem.	м0080)3 Ro	ckvil ckvil	lle,	Inc. Mary	300 1and	West 2085	Mont 50-28	phre gome 05	y Fun ry Av	eral Home/ enue
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that cause nly one cause on each l	d the death. line.	Do not ente	er the mode	of dying	, such as	cardiac (or respiratory	arrest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Mult	ple co	ottona	wou	and:	S						Onset and Death
	/Medical . Examiner		resulting in death)	Due to (or as	s a conseque										
		e	Sequentially list conditions,	b. Due to (or as	a conseque	nce of).								_	
	nsit	in in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	255 (5) (5)	o a comocquoi	100 01).									
,	s be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as	a consequer	nce of):	_							-	
8760,	cate be ex physician the buria	dlcal		d.											
9	tificate ig physias the	0)													
Вох	death certificate be executed e attending physician and d for use as the burial-transit	lan/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pre	000000					23d. Dat	e of deliven	у
	ie dea the att hed fo	sicie	in the past 12 months?	4□Pregnant a			Other (spe					. 11911	Mor	nth D	Day Year
P.0	at the	Physici	9 Unknown												
	es gu pe	b	Part II. Other significant condition	s contributing to death t	out not resulti	ng in the un	iderlying ca	use giver	n in Part I.						cause of death?
010	w requir been si should	eted									1	Yes 2	No No	3 ☐ Probat	bly 4 Unknown
Records,	2 8 2	Completed										opsy	P	rior to comp	sy findings available pletion of cause of
	Th ate pag										1 X Yes	formed? 2 🗆 No		eath? Yes 2	!□ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:							(Check only				
ō	Phys rthis ral dii	. To	Yes 2 No 27. Manner of Death	28a. Date of Inju		VOutpatient Bb. Time of		Other	4 INUI	_	me 5 Re 28d. Describe				
on	ding Ih. After funer	tion	1 ☐Natural 5 ☐ Pending	Found Month, Da	ry Year) Fo	lg@ry		Work?			subje ct		CUV		
Division	I or Attanding after death. Diractor: Afte I in by the fune	Certification;	3 Suicide 6 □ Could no	t be 2 e. Place of In	iury - At home	a, farm, stre			2 2 92 4	-					Route Number,
É	in Direct	erti	4 Homicide	building, et	tc. (Specify)		-,,,				City or T	own. State	9)		
	Hospital		29a. Certifier 1 Certifying	Physician: To the best	of my knowle	dge, death	occurred a	t the time	, date and	place, a	and due to th	e cause/s) and mar	ner as stat	ed to the
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only one) Medical Ex	caminer: On the basis of and manner st	of examination	and/or inv	estigation, i	in my opi	nion, death	occurre	ed at the time	, date and	d place, a	nd due to th	he cause(s)
	Veith To 1	Σ	29b. Signature and title of certifier					License CME	number					(Month, Da	ay, Year)
}	1	/	Jasha ? M	renhera	MD			~ PIE				APKI	.L L/	, 2004	
	1 0		30. Name and address of person wh	no completed cause of	death (Item 23			·	~± -	-1.		14	.1 3	2120	1
			Tasha Z CIVER 31. Date filed (Month, Day, Year)	riberg M	rar's Signature		em S	oure	eτ, Β	a_ti	more,	mary	Land	ZTZ 0	1
*	Sta Registr		APR 2 1 2004	Serve a	ar s Signatur		rocks	/							

		1 - For State Registrar	State of Mary	land / Dep			lental Hygie	•	12050
Physic /Medi	cal	1. Decedent's Name (First, Middle, Las William F. Good	ch		I		2. Date of Death Month April 1	Day Year 9 2004	3. Time of Death
Examir		4a. Facility Name (If not institution, give 719 Maiden Choic 5. Social Security Number 6. Se	e Lane, BR4	35	Catons	r Location of Death	Date of Birth	4c. County of Dee	more
Funeral Director			X 2□F 85	yrs. last birthday Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y 9/4/1918	ear) 9. Bir Co Del	thplece (State or Foreigountry) .aware
death with the Maryland rms 23a or 28a-f show rmust be notified at	ctor	Maryland Baltimor		:. City, Town or L Catonsvi					10d. Inside City Limits
th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 719 Maiden Choice	Lane		10f. Zip Code 212	28		. Citizen of What Co JSA	ountry?
036 or, or its	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🗓 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: V	
5-0 72 hc	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		16a. Dece (Give life.	dent's Usual Occup kind of work done DO NDT use retired	nation during most of working)	ng 161	b. Kind of Business	/Industry
trad Hy oth other	To Be Cor	12 17. Father's Name (First, Middle, Last) Clifton Gooch		Fa	ctory Wor		(First, Middle, Mai	Mfg. iden Sumame)	
		19a. Informant's Name/Relationship (7) Connie Mackowiak /	•			and Number or Rura Hill, Anna			
Baltimore, permit. Pages 1 ar Department of Hea mportant: If Item nny injury or othe		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ I 4 ☐ Domation 5 ☐ Other (Specify,	Removal from State	b. Place of Dispo cemetery, cre	osition (Name of matory or other place Crematory	(e)	ate 200	c. Location - City or	
Baltimo permit. Pages Department of important: if it eny injury or ance.		21. Signature if Funeral Service Licens	Sind 2		2. Name and Addre	111	ubbard Fu	neral Hom	
Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the cause on each line. Attended Due to (or as a continuous)	lenter	Carlor	ng, such as cardiac o	Process		Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a con						
BOX 58/6U eath certificate be executed attending physician and for use as the burial-transit	cal	resulting in Jean Last	Due to (or as a cond.	isequence of):					
HECOIDS, P.O. BOX 68 The law requires that the death certifica site has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ f 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
w requires that been signed be should be deta	d by P	Part II. Other significant conditions co	ntnbuting to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobace		the cause of death?
VITAL HECOTOS, strien: The law requires to certificate has been signe lirector, page 2 should be or	Completed by						24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
<u> </u>	To Be C	25. Was case referred to medical examiner? 1 \(\sum \text{Yes} \) 2 \(\overline{\nu} \) No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatier	it 3 DOA Oth	26. Place of Death er: 4 ☐ Nursing Hon	(Check only one)	e 6 □Other (Spec	
UIVISION OF To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yea	28b. Time o r) Injury	Worl	/ at <br Yes 2 □ No	8d. Describe how in	njury occurred	
itel or Att its after d rat Direct led in by t		4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	ecify)			City or Town, Si	<u> </u>	
UNISIGE DIVISION To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one)	sician: To the best of my ner: On the basis of exan and manner stated.	knowledge, death nination and/or in	vestigation, in my of	pinion, death occurre	d at the time, date	and place, and due	to the cause(s)
2 × 100	N	29b. Signature and title of certifier Odlar Byllis-	Je mo		D2			Date signed (Month	
7 1		Name and address of person who co	RAHAM	1001	Print) PINE	Heights	AVE. B	ALTO M	D 2/229
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's S	ignature 					

ORIGINAL

			1 - For State Ragistrar	State of Ma		Depa		Health :	and Me	ntal Hy			12061
	Physicia /Medic		Decedent's Name (First, Middle, Last LOUIS	"		GE	ORGE			. Date of De			3. Time of Death 11:15P M
	Examin		4e. Facility Neme (If not institution, give 5912 Smith Ave				4b. City, Town,					County of Deel	th
	Funeral		Social Security Number	x 7. Age	e (In yrs. last	birthday)	If Under 1 Yea			Date of Birt		N/A 9. Birt	hplace (State or Foreign
	Director		214-01-6310 15 Usual Residence of Decedent	X X 2□ F	95	Yrs.	Months Days	Hours	Min. De	Date of Bird (Month, Da CENDEY	2,190	8 M	aryland
	the Maryland 28a-f show	2	10a. State 10b. County		10c. City, To								10d. Inside City Limits
	r 28a-f	irecto	Maryland N/A 10e. Street and Number		Balt	imor	e 10f. Zip Code				10g. Citiz	zen of What Co	VXYes 2 □ No ountry?
	a 23a c	eral D	5912 Smith Avenue	10 W- D 1-1		140.1		21209				USA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itama 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be mutified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married XX Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes A(A) N If Yes, Give Year or Dates:	ever in U.S.	1	Vas Decedent of Yes, specify Cul			y Yes or No an, etc.)		I4. Race - Ame Black, White Specify:	
21215-0036	in 72 h	ojetec	15. Decedent's Edu (Specify only highest grad	le completed)	16	Sa. Deced	ent's Usual Occu kind of work done OO NOT use retin	ipation during mos	st of working		16b. Kin	nd of Business/	Industry
212	ed withi /giene. rer than	Comp	Elementary/Secondary (0-12)	College (1-4or 5	+)		al FOren				_Ste	eel	
Maryland	iould be file Mental Hy harked oth	To Be	17. Father's Name (First, Middle, Last) William George					A	er's Name (F ddie J	ohnsoi	n		
	nd 2 sh alth and 27 is m r traum		19a. Informant's Name/Relationship (T) Julia Haynes	уре, Print) DT			g Address <i>(Stree</i> Smith <i>A</i>						
Baltimore,	ges 1 a t of Hea if item or othe		20a. Method of Disposition 1 XX surial 2 Cremation 3 F	Removal from State	20b. Place cemel	of Dispos	sition (Name of atory or other pla	ace)	Date	1	20c. Loc	cation - City or	Town, State
altim	nit. Pa partmen oorlant: Injury		*4 Donation 5 Dother (Specify) 21 gnature of Funeral Solvice Licens	1-1	Druid		ge Cemet						, Maryland Home Inc,
Ä	Deg any	_	Lennes Syste	n Cnas	0			6500	York Ro	oad Bal	timore	e, Maryla	
760,	Physician /Medical Examiner per partial-Itansit physician and physicia	Examiner	23a. Part1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	Signature of the second of the	e of):							Approximate Interval Between Onset and Death
P.O. Box 6876	it the death certificat by the attending phy ached for use as th	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 Fetal deat time of death	5 🗆	Ectopic pregnanc Other (specify) _				23	3d. Date of delin	very Day Year
	quires tha	þ	Part II. Other significant conditions cor	ntributing to death bu	t not resulting	in the un	derlying cause gr	ven in Part I.			bacco us es 2)2		the cause of death?
I Records,		Completed								24a. Was a autops perform	sy	24b. Were aut prior to co death?	opsy findings available ompletion of cause of
Vital	sician: Th certificate irector, pag		25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	it 2□ER/O		- Ott		of Death (Cl	heck only or	18)		
on of	ading Phys th. : After this s funeral di	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		Time of Injury	28c. Inju	4 🗆 Nur	28d.	Describe ho		□Other (Speci occurred	fy)
Division	al or Attendi safter death. i Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.	ry - At home, f (Specify)	farm, stre	et, factory, office		28f.	Location (St City or Town	treet and n, State)	Number or Rur	al Route Number,
		Medical	29a. Certifier (Check only one) 12 Certifying Physical Cartifying Physical Examination (Check only one)	sician: To the best of ner: On the basis of a and manner stat	examination a	ge, death nd/or inve	occurred at the ti estigation, in my o	me, date and opinion, deat	d place, and the occurred a	due to the ca t the time, d	ause(s) a ate and p	nd manner as s lace, and due t	stated. o the cause(s)
		Σ	29b. Signature and title of certifier	24			29c. Licens			2		signed (Month,	
	13		30. Name and address of person who co	impleted cause of de	ath (Item 23a)) (Type, P		3022				1120,	
			Crong Gold Do 15	32. Registrar	e Tre	e Re	od A13	5 B	attim	Die il	Mary	land 2	1208
	Stat Registra	_	APR 2 1 2004	Severa	G	dos	this "	··					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** APRIL 18, AILEEN 2004 6:30AM HALL /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Forest Glenn Nursing Home Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) May 11, 1919 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplece (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖾 F 84 Maine 004-14-3743 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. The Medical Examinar must be notified at Wheaton 1 Yes 2 No Montgomery Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20902 3705 Adams Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene important: if Item 27 is marked other than "natural; or item any injury or other traumatic event, the Medical Exemina 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation Coupation

(Give kind of work done during most of working
life. DO NOT use regired)

Director of Pre—School Parent
Education, Maryland School for the Deaf State of Maryland College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Springer Boutilier Jesse 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6714 Gude Aveune Takoma Park, MD 20912 19a. Informant's Name/Relationship (Type, Print) Stephanie A. Hall (Daughter) 20b. Place of Disposition (Name of Aprilate 20 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Chesapeake Crematory Beltsville, MD 2004 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral And 933 Gist Avenue Cremation Services Silver Spring, MD 20910 Stiple D'Xohmann M00382 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy lor in the past 12 menths? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No been signed by the should be detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has page 2 autopsy performed 1 Yes 24 No or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Tes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. 29d. Dale signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number cause of death (Item 23a) (Type, Print) 30. Name and address of person who comple Ron MO 1. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar APR 2 1 2004

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F			ene 200	14 12064
	Physici		1. Decedent's Name (First, Middle, Last) Mary Alice Ho	ott				2. Date of Death Month April 4	Day 2004	3. Time of Death 3:00AM M
	/Medic Examir		4a. Facility Name (If not institution, give s Memorial Hosp	street and number)		4b. City, Town, o	or Location of Deat	h	4c. County of D	eath
*	Funeral Director		220-10-7228	7. Age	(In yrs. last birthday, 83 Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) June 24,	9. 1920 Pe	Birthplece (State or Foreign Country) ennsylvania
	Ba-f show	Director	Usual Residence of Decedent 10a. State 10b. County WV Minera	1	10c. City, Town <i>or</i> L Key	ser				10d. Inside City Limits 1 X Yes 2 ☐ No
21215-0036	d within 72 hours after death with the Maryland jene. r than "natural", or items 23a or 28a-f ehow the Mazical Exantrec must be maillied at	Completed by Funeral Dire	10e. Street and Number 1435 Chandell St 11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	16a. Dece	Was Decedent of H If Yes, specify Cub 1 Yes 2 No dent's Usual Occup, kind of work done DO NOT use retire	Specify: pation during most of wor	specify Yes or No- o Rican, etc.)		mencan Indian, thite, etc. White
Maryland 21	be filed ntal Hyg ed othe event,	To Be Con	11 17. Father's Name (First, Middle, Last) Edward Francis M			erk & Boo	18. Mother's Nar	ne (First, Middle, Ma lda Agnes	Tahaney	
	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Typ. Janice K. Cannon/	•				ural Route Number, (t Keyser,		2-1/27
Baltimore,	tof File		20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Ro 1 □ Donation 5 □ Other (Specify)	emoval from State	20b. Place of Disponentery, cre		ce) Apri	Date 20	oc. Location - City	or Town, State
Balt	permit. Pa Departmen Important: any injury QDC6.		21. Signature of Funeral Service License	Frute		2. Name and Addre	uneral Ho	ome Keys	S. Main S ser, WV	
8760,	Physician /Medical Examiner	icai Examiner	23a. Part1. Enter the disease, or complications shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last	Septic Due to (or as a Bowel in	pulmonary consequence of): nfarction consequence of).		ng, such as cardiac	c or respiratory arres	,	Approximate Interval Between Onset and Death uk hrs uk days 8 days
P.O. Box 68	the death certific by the attending p ached for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Tho 9 □ Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic pregnanc; □ Other (specify) _	1		23d. Date of Month	delivery Day Year
	w requires that been signed t should be det	þ	Part II. Other significant conditions con	tributing to death but	t not resulting in the u	inderlying cause giv	ren in Part I.			e to the cause of death? Probably 4 Unknown
Vital Records,		Completed						24a. Was an autopsy performe 1 Yes 2	prior	autopsy findings available to completion of cause of ? es 2 \(\text{No} \)
Division of Vit	Attending Physician: r death. ector: After this certific by the funeral director.	ertification; To Be	25. Was case referred to medical examiner? 12. Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	ospital: 1 Inpatien 28a. Date of Injury (Month, Day March 27	Year) 28b. Time of Injury 04 ard 6	f 28c. Injur Wor : OOPM 1□	er: 4 Nursing H		fell at	home
Divi	oital or Attendurs after death oral Director:	O	4 Homicide determined	residen				1435 Char	State) ide11 St	Rural Route Number, Keyser W.Va
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	ledical	29a. Certifier (Check only one) 1 Certifying Phys	ner: On the best of er: On the basis of e and manner state	examination and/or in	vestigation, in my o	pinion, death occu	rred at the time, date	and place, and d	lue to the cause(s)
)	To So To To	2	29b. Signature and title of certifier	1/6		29c. Licens D091			Date signed (Mo April 19	
	4		30. Name and address of person who compaul Snow, M.D.	Dpty Med	ath (Item 23a) (Type, Ex 124 W	3rd St C	umberlan	d Md 21502	2	
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 1 2004	82. Registrar	r's Signatura	books				

				1 - For State of Maryland / Dep	partment of Health and Mertificate of Death	lental Hygier	
		Physici /Medic		1. Decedent's Name <i>(First, Middl</i> e, Last) Margaret W. Hartley		2. Date of Death Month April 8,	3. Time of Death 2004 12:43 p. M
		Examir		4a. Fecility Name (If not institution, give street and number) Broadmead	4b. City, Town, or Location of Death Cockeysville		4c. County of Death Baltimore
	K	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 82 Yrs.	Months Davs Hours Min.	8. Date of Birth (Month, Day, Yea Jan., 18, 1	9. Birthplace (State or Foreign Country) 922 China
		Maryland If show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I MD Baltimore County Cou	Location ockeysville		10d. Inside City Limits 1 ☐ Yes 2昼 No
3011		th with the 23a or 28s	ai Director	10e. Street and Number 13801 York Road	10f. Zip Code 2 1030	10g. (Citizen of What Country? USA
13:43pm	5-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: if item 27 is marked other then "natural", or items 23a or 28a-f show injury or other traumatic avant, the Medical Exaticity rutal be notified at injury or other traumatic avant, the Medical Exaticity rutal be notified at a.	by Funeral	11. Marital Status 1 Never Married 2 Married 3.X.Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I □ Yes 2 No Specify:	ectly Yes or No- Rican, etc.)	14. Race · American Indian, Black, White, etc. Specify: White
	21215-0	ithin 72 ho ne. nen *natur Medical	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4 or 5+)	edent's Usual Occupation re kind of work done during most of workii DO NOT use retired)	ing	Kind of Business/Industry
1	and 21	2 should be filed with and Mental Hygiene. Is marked other than aumatic avant, the	Be	12 4 17. Father's Name (First, Middle, Last) Henry Milton Wagner		(First, Middle, Maide	vn Home en Sumame) Corson
race,	Maryland	d 2 should I th and Men 7 is marke traumatic	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	iling Address (Street and Number or Rura	al Route Number, City	
6/8/	Baltimore,	permit. Pages 1 and 2 Department of Health Important: If Item 27 I any injury or other tra anges.		20a. Method of Disposition 20b. Place of Disp			Location - City or Town, State
7	Balti	permit. Departn Importa sny inju		Ronald S. Wade, Director per DVR	22. Name and Address of Facility State Anatomy Board Baltimore,MD 21201		Baltimore Street
		Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	nter the mode of dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between Onset and Death
FY	8760,	ate be executed hysician and the burial-transit	licai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):)	
RTL	O. Box 68	requires that the death certificat een signed by the attending phy nould be detached for use as th	Physician/Med		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
HA	ds, P.	luires that the signed by all do be detact	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death? 2 □ No 3 □ Probably 4 ⊠Unknown
1	al Record	as b	Completed			24a. Was an autopsy performed?	
M	Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatit	26. Place Death	10	2 Flow - (2 - ()
A. K.	on of	ing Phy a. After this funeral d	!	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 2. The spiral of Inpatient 2 ER/Outpatient 2. The spiral of Injury (Month, Day Year) Injury 2 Accident investigation	of 28c. Injury at 2	28d. Describe how in	6 Other (Specify)
ARC	Division	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street and City or Town, Sta	and Number or Rural Route Number, te)
5		To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal call Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurred.	and due to the cause ed at the time, date a	(s) and manner as stated. Indiplace, and due to the cause(s)
		To the To the complex	Ä	29b. Signature and title of certifier Barbara Carall, Mil	29c. License number D 3 83 92	29d. C	Date signed (Month, Day, Year) 4/9/2-004
	_			30 Name and address of person who completed cause of death (Item 23a) (Type BARBARA CARROLL, ND),	9, Print) 13801 Vork	Rd.,	Cockeysville.
		Sta Regist	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	books	/	UMD 21030

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** MURTEL NAOMI HOCH /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ro 50 000 Dan JMOV If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 16 If Under 1 Year Birthplace (State or Foreign Country) Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🂢 F 70 215-30-3427 Yrs. Feb. Director 1934 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1X Yes 2 □ No Maryland N/A Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3012 Mathews Street 21218 Funeral U.S.A.12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □ Yes 2X No þ 3 Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Importent: if item 27 is marked other than "na any injury or other treumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) 12 years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Potee Grill Mildred 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Hoch 3012 Mathews Street (husband) Baltimore. Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 4/20/04 Green Mount Crematory Baltimore, Maryland ^{22, Name and Address of Facility}
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21212 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 40con /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy 1 Live birth 2 | Fetal death in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) the 1 □ Yes 2 No signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Į 1 🗌 Yes 2 EB/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Natural 5 Pendina М 1 □ Yes 2 □ No death. investigation 2 ☐ Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, Print) el -dware 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1- State of Maryland / Department / Departmen	artment of Health and rtificate of Death	Mental Hygie	2001
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time-of Death
	Physici /Medio		Richard Joseph Bernard Harbin		April	17 2004 4:55 P M
	Examin		4a. Facility Name (If not institution, give street and number) Gilchrist Center	4b. City, Town, or Location of Dea		4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 219-22-8192 6. Sex 1X M 2 F 7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year If Under 24 Hr Months Days Hours Mir). (Month, Day, Ye	9. Birthplace (State or Foreign Country) 10,1927 Dist. of Colu
	within 72 hours after death with the Maryland ene. than "naturet", or Items 23a or 28a-1 show he M. digal Examinet mat be nuffind at	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lot	ocation		10d. Inside City Limits 1 ∐Yes 2 🛣No
	28a-	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	h with		740 Camberly Cir., Apt. B4	21204		United States
"	s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-1 show other treumatic event, the Modical Examiner must be notified at	Funeral	Armed Forces? 1 1 □ Never Married 2X Marned 1 X Yes 2 □ No	Was Decedent of Hispanic Origin? (if Yes, specify Cuban, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
-0036	hours a furel', o	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: ₩₩ II	1 ☐ Yes 2 X No Specify:	161	Specify: white
21215-0036	within 72 ine. ihan na	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give life. I	kind of work done during most of w DO NOT use retired)	orking	,
	filed v Hygie other t		17. Father's Name (First, Middle, Last)	owner/operator 18. Mother's Na	ame (First, Middle, Mai	nterior design
Maryland	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the M	To Be	Frank P. Harbin	Corin	ne Marie Lo	othrop
Mai	d 2 sh th and 7 Is n treun		0500	ng Address (Street and Number or F Buckhorn Rd.	Rural Route Number, C. Baltimore,	
	Health tem 27 other tr		20a. Method of Disposition 20b. Place of Dispo	sition (Name of		Location - City or Town, State
E C	Pages nent of I nnt: If its iry or o		1 M Burial 2 Uremation 3 Hemoval from State	s-Govans Cem. Apr	. 21 . 2004	Baltimore, Maryland
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr 2002.			Name and Address of Facility Mitchell—Wiede 6500 York Rd.		al Home, Inc.
	,		23a. PA1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	PANCER		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequency f):			Jean
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
	be executed ician and burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
8760,	icate be ex physician s the burial	dical E	d d			
9	rtificate ng phys as the	Medi	IF FEMALE			
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
4	quires that the signed by and be detacted	by	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		co use contribute to the cause of death? 2 \(\sum \) No \(3 \sum \) Probably \(4 \sum \) Unknown
Records,	The law requir ate has been si page 2 should	Completed			24a. Was an autopsy performed	
Vital	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of De	eath (Check only one)	
of V	Physicien: this certific ral director,	ပို	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien		Home 5 Residence	
		tion:	27. Manner of Death 1	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred
Division	or Attending Physicien: after death. Director: After this certific in by the funeral director,	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, strubuilding, etc. (Specify)		28f. Location (Street	and Number or Rural Route Number,
Ö	ospital or A hours after unerel Direc ly filled in by				City or Town, S	
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death and manner stated. Check only one)	n occurred at the time, date and place vestigation, in my opinion, death occurrence.	e, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier Marthay Miley . Mo	29c. License number	29d.	Date signed (Month, Day, Year)
	9		30. Name and address of person who completed cause of Seath (Item 23a) (Type, W. A. Riley G. B.M.C. 6701 N.C.	Print) Rales St. Ba	Cto. md =	21201
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 1 2004 32. Registrar's Signature	loak!		2120x
			MIN N - LUUT			

Yarbin, Richard 4-17-04 Hissp

State of Maryland / Department of Health and Mental Hygiene 12068 1 - State Registrat Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2004 11:30 AM Hoover April Frances Ina /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Casey House Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth June 16, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 💢 F 54 Yrs Virginia 216-58-8091 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County it of Health and Mental Hygiene. If item 27 is marked other than "naturel", or iteme 23a or 28a-f ehow or other treumatic event, Ite Modical Examines must be notified at MD Germantown 1 Yes 2 No Montgomery Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with it Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or iteme 23a or 21 any injury or other treumatic event, Ita Malical 20874 U.S.A. 19525 Waters Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐Yes 2XINo fYes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: If Yes, Give Year or Dates: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Manager Mini storage 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Patton George Burress ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Roger D. Hoover - husband 19525 Waters Rd., Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation 4/19/2004 Sykesville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Foreral Service Li 22. Name and Address of Facility Hartzler Funeral Home Maure 11802 Liberty Rd., Libertytown, MD 21762 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Breast Cancer metastatic to central nervous system Physician 3 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any saling I imported cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical attending physic for use as the b 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ned by the a ☐Yes 2XNo Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1□ Yes 2√2 No 1 Yes 2 No Vital the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 일 Hospice o this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: After Division 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai within 24 ho
To the Fune 29d. Date signed (Month, Day, Year) 29c. License number m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Rd., Rockville, MD 20855 Charles Harrison MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) Sporker Registrar APR 2 1

	 Decedent's Name (First, Middle, 	_ast)		2. Date of Death		3. Time of Death
sician	BORRAKA	CARLEZA JA	se kom	Ant 6	Day Year	7:30A
edical miner	4a. Fecility Name (If not institution,		4b. City, Town, or Location of Deat	h	4c. County of Deat	,
		11-WHYE LAY	¿ Montofon		Bolt	
rai	5. Social Security Number	Sex 7. Age (In yrs. last I	birthday) If Under 1 Year If Under 24 Hrs Yrs. Months Days Hours Min.	8. Date of Birth Month, Day, Y	(ear) 9. Birt	thplace (State or Foreignantry)
r	Usual Residence of Decedent	67	113.	Hug. 4, 1	939 MI	my/mo
	10a. State 10b. County	10c. City, To	own or Location			10d. Inside City Limit
tor	MAKYLOND BALL	MOTE MO	inktow			1 ☐ Yes 2 🔀
Olre	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Co	ountry?
Funeral Director			ne 21/11		USA	
une	11. Marital Status 1 □ Never Married 2 ■ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	14. Race - Ame Black, Whit	
by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify B &	ck
ted	15. Decedent's	Education 16	Sa. Decedent's Usual Occupation	16	ib. Kind of Business/	Industry
Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of wo life. DO NOT use retired)		2 / 0	
Con	12H grade	F.	Actory Worker		Ector - D.	IC ICINSON
Be	17. Father's Name (First, Middle, La			me (First, Middle, Ma		
은	Grant M. THER		E/EANE.	~ Chom		7-0-1-1 6 6 6 6
	19a. Informant's Name/Relationshi	121	9b. Mailing Address (Street and Number or Ri	/		
	20a, Method of Disposition	(50) / 1/03 Bmn (6),20b. Place	of Disposition (Name of	Date 20	c. Location - City or	Town, State
	1° Seurial 2 ☐ Cremation 3	ceme	terv, crematory or other blace)	10 10 11		
ند	* 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Li	ehree	22. Name and Address of Facility	1 - For AU	- Umil	Knist Kon
Special	June 1	6	22. Name and Address of Facility (52 Y KEISTERS) 1301 HILLS INS	town Red	cr	
	23a. Part 1. Inter the Jsease, or co	emplications that caused the death. D	o not enter the mode of dyin, such as cardia	c or respiratory arrest	t,	Approximate
	Immunite Cause (Final	RESPIRA				Interval Between Onset and Death
n ii	disease or condition resulting in death)	Due to (or as a consequence	ee of):			ک سالا
	Conversion to the constitution	ASTHM	a/cupp			10%
ner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying	Cua to (or as a consequence	e of je			- 0
Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c				
	rooming in county such	Due to (or as a consequent	e or;			
dical		d				
Physician/Med	IF FEMALE:	23c. If yes, outcome of pregnancy			23d. Date of del	iverv
ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death	ath 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
hysi	9 Unknown	9□ Unknown				
by P			g in the underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ed	ola palv		150211.	1 → Y6s	2 No 3 Pr	obably 4 Unknow
ompleted	atricl fo	Snillatur		24a. Was an autopsy	24b. Were au	itopsy findings availal completion of cause of
E O				performe	d? death?	2 - No
BeC	25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)		
10	1 Yes 2 No	Hospital: 1 Inpatient -2EEN		lome system		cify)
on:	27. Manner of Death 1 □ Natural 5 □ Pending	(Month, Day Year)	D. Time of 28c. Injury at Work?	28d. Describe how	injury occurred	
Medical Certificati	2 Accident investigated and Suicide 6 Could not	t he	M 1 Yes 2 No	206 Leasting (Star	et and Number or Ru	and Charles Alice bas
Certification:	4 Homicide determin	28e. Place of Injury - At home, building, etc. (Specify)	rarm, street, factory, office	City or Town,		ar noute Number,
	29a. Certifier 1 Certifying	Physician: To the best of my knowler	Ige, death occurred at the time, date and place	and due to the caus	se(s) and manner as	stated
edical	(Check only 2 Medical E	teminer: On the basis of examination and manner stated.	and/or investigation, in my opinion, death occi	urred at the time, date	and place, and due	to the cause(s)
₩	29b. Signature and title of certifier	O a MI AH	29c. License number		. Date signed (Monti	h, Day, Year)
	Welli E	1 could pr	pul D15808	mp	4-9-1	
	30. Name and address of person w	no completed cause of death (Item 23)	a) (Type, Print)			5104
	WILLIAMER	anousce, Ja	1205 PURC R	D Lute	4620116	E. Ma
		an Design de Cierce		.7		
	31. Date filed (Month, Day, Year)	32. Registrar's Signature	j j	19		
State gistrar	31. Date filed (Month, Day, Year)	2. 1 2004 Egyer	a) (Type, Print) 1205 Year R Lean B Sports	1		

Johnson, Rosemark

			Please Type or I State of For State Registrar	Maryland / [Departmer		d Mental Hygie	•	+ 12071
	Physicia /Medic		Decedent's Name (First, Middle, Last) Rosemary Isner Johnson			7	2. Date of Death Month April	Day Year 19, 2004	3. Time of Death 9:15P M
	Examin Funeral Director	er	4a. Facility Name (If not institution, give street and num Greater Baltimore Medica 5. Social Security Number 6. Sex 234-10-3226 Usual Residence of Decedent	1 Center 7. Age (In yrs. last bir	Tow	1 Year If Under 24 h		(ear) Coul	place (State or Foreign
:	ith the Maryland or 28a-f show	tor	10a. State 10b. County Maryland Baltimore Count	10c. City, Town	n or Location Balti	more			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
2	ath with the 23a or 28	rai Director	10e. Street and Number 6451 North Charles Stre		10f. Zij	21212		USA	
2-00-0	n 72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show adical Examinat rust be milited at	by Funerai	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Ves 1 □ Ves 1 □ Yes, Giv Year or Da	² X ^{No}	13. Was Dece If Yes, spe	dent of Hispanic Origin? cify Cuban, Mexican, Pu 2 No Specify:	(Specify Yes or No- lerto Rican, etc.)	14. Race - Americ Black, White, Specify: W	
0-6121	filed within 72 hours after death with the Maryla Hygiene. Ither than "natural", or Itams 23a or 28a-f show ant, the Madical Examinat must be multitled at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1	-4or 5+)	Decedent's Usu (Give kind of wo life. DO NOT L Tomemake	rk done during most of se retired)	working 16	Own Resident	
⊑	e filed al Hyg I other vant,	To Be Co	17. Father's Name (First, Middle, Last) Clarence	Isne <u>r</u>		18. Mother's I	Name (First, Middle, Ma	oberly	
Mar	s 1 and 2 should to if Health and Ment itam 27 Is markad other traumatic e		19a. Informant's Name/Relationship (Type, Print) Kend1 Price Philbrick 20a. Method of Disposition	24	_	on Hurst Co	Rural Route Number, Court, Fallst	•	and 21047
	permit. Pages Department of Important: If it any injury or o		1 → Burial 2 □ Cremation 3 □ Removal from 3 ↓ A □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Leensage	State	ev Valle	v Mem Grdns	s 4/23/2004 dd Funeral	Timorium,	Maryland
			Martin D. Lawson 23a. Part1. Enter the disease, or complications that control shock, or heart failure. List only one cause on elimmediate Cause (Final	aused the death. Do nach fine.	6500 not enter the mod	Yark Raad, le of dying, such as card	Paltimore,	Maryland 2	21212 proximate Interval Between Onset and Death
	Physician /Medical sician and partial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	or as a consequence	of):	-U/LE			
. Box 687	death certificate e attending phy: d for use as the	by Physician/Medical	23b. Was decedent pregnant 1 Live b	come of pregnancy irth 2 Tetal death ant at time of death own	3 □Ectopic p			23d. Date of deliver	rery Day Year
rds, P	The law requires that the ste has been signed by th bage 2 should be detache		Part II. Other significant conditions contributing to de	eath but not resulting in	n the underlying	ause given in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to t	the cause of death?
		Completed					24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
i Vit	Physician: The I this certificate ha al director, page	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No Hospitaí: 1 ☑ 1	npatient 2□ER/Ou	utpatient 3 D	Other: 4 Nursin	Death <i>(Check only one)</i> g Home 5 Residen	ce 6 □Other (Specif	fy)
Division of	ttending I death. ctor: After / the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place	of fnjury - At home, fa	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how 28f. Location (Stre	et and Number or Rura	al Route Number,
2	spital or A ours after naral Dira filled in by		4 ☐ Homicide buildi 29a. Certifier 1 ★ Certifying Physician: To the	ng, etc. (Specify) best of my knowledge	e, death occurred	at the time, date and pl	City or Town,		stated.
	To the Hospita within 24 hours To the Funaral completely filled	Medical	(Check only 2 Medical Examiner: On the ba	asis of examination and ner stated.	id/or investigation	, in my opinion, death o	ccurred at the time, date	and place, and due to	to the cause(s)
	D		30. Name and address of person who completed caus	e of death (Item a)	(Type, Print)	0-44728	C + C + C	1/20	21004
	Sta Regist	ate	31. Date filed (Month, Day, Year) 32. R	egistrar's Signature	1.	loake		U 1/1/1/1	One's
DH	MH 17 Rev 1/2	-	APR Z 1 2004	Deperson	P	porker			

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 2004ª 16, **Physician** Kashe Ramona 11:55A. M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 30, 1917 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 200 F 516-03-1023 Montana Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ital Hygiene. d other than "natural", or Items 23a or 28a-f ebov event, Ita Medical Examinar must be rediffied at 1 ☐ Yes 2 XNo Maryland | Montgomery Silver Spring Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20910 United States 9510 Pin Oak Drive death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-Il Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite ury or other traumatic event, Ital Medical Examina 1 Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates: Completed by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Kall Anna Seman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9510 Pin Oak Drive Silver Spring, Maryland 20910 Richard Kashe -son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or Metropolitan Crematory 4/19/2004 Alexandria, Virginia Donald V. Borgwardt Funeral Home, P.A. 21. Signature of Funeral Service License 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Pulmonary Edema disease or condition resulting in death) 24 hours /Medical Due to (or as a consequence of): Examiner Hypoxic Encephalopathy 24 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) as the burial Box 68760 IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? Month Day ō 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0 detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. δ Records. should be Aortic Stenosis; Alzheimers Disease 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Xnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 2 After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Kannahat M. D20062 April 19, 2004 Jonn P. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tony P. Kannarkat, M.D. 8201 16th Street Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 32. Registrar's signature

DHMH 17 Rev 1/2001

State

Registrar

APR 2 1 2004

		For State Registrar		State of M	iarylan		artment o		d Mental Hy	/giene Reg. No.	2001	12072	
		Decedent's Name (First, Middle, Last)							2. Date of D	eath		3. Time of Death	
Physician /Medical		Irene Bennett Kimball							April	i 8	2004	502 AM	
Examin	er	4a. Facility Name (Mariner	(If not institution, give	e street and number	Bei	Air	Bel	m, or Location of D	MD	+	County of Death Har Fo	rd	
Funeral Director		5. Social Security 1 220-46-	·1936 1	ex 7. A	ige (In yrs.	97 Yrs.) If Under 1 Y Months Da		Hrs. 8. Date of B (Month, D	irth Jay, Year)	9. Birth Col Ok l	place (State or Foreign intry) .anoma	
urs after death v		Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or L	ocation					10d. Inside City Limits	
	tor	OK	OK Payne				Stillwater					1 ☐ Yes 2 No	
	Director		De. Street and Number				10f. Zip Code			10g. Citizen of What Country?			
		5505 W. 19th Street 11 Marital Status 12. Was Deceder			74074				2 (Coopily Van or A		ited States 14. Race - American Indian,		
	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 □ Married 2 □ Married 1 □ Yes 2 □ If Yes, Give year or Date			s? If Yes, spe ⊇No 1 ☐ Yes			cedent of Hispanic Origin? (Specify Yes or No pecify Cuban, Mexican, Puerto Rican, etc.) 2xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx			Black, White, etc. Specify: American Indian		
		15. Decedent's Education				16a. Dec	edent's Usual O	s Usual Occupation		16b. Kir	. Kind of Business/Industry		
	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+				(Give kind of work done during most of working life. DO NOT use retired) Homemaker					Home		
	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Ma				The second second		
	70	William U. Bennett						Amy Isabella Callahan					
		19a. Informant's Name/Relationship (<i>Type, Print</i>) Mr. Frank B. Kimball/Son 21 Oyster Landing											
		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State				Place of Disp cemetery, cre	osition (Name of amatory or other	of place)	ildy i			own, State	
		21. Signature of Funeral Service Licenspe WOOSC 22. Name and Address of Facility Cremation and Funeral Alternatives											
		8717 Green Pastures Drive Baltimore, MD 23a. Pertl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate										Approximate	
	er	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										Onset and Death	
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or mult) that initiated events resulting in death) Last Due to (or as a consequence of): c. Due to (or as a consequence of):											
				d									
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dead 4 Pregnant at time of death 9 Unknown				al death 3	ath 3 □Ectopic pregnancy				23d. Date of delivery Month Day Year		
	by	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
	Completed									opsy formed?	24b. Were aut prior to condeath?	opsy findings available ompletion of cause of	
	BeC	25. Was case refe	erred to medical					26. Place of	Death (Check only		12 163	2010	
	To E	1 Yes 2 No 1 Inpatient 2 EP/Outpatient 3 DOA Owner: 4 Nursing Home 5 Residence 6 Other (Spec								ify)			
	ation:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation					of 28c.						
	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location City or T	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	edical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated.											
	M	29b. Signature and title of certifier M3				29c. License number D34652 pe, Print) MHE Bel Air Mary /			29d. Date signed (Month, Day, Year) April 19, 2004				
			NI	MI				0 3/03 6		13(PV)	1 17, 2	UT	

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2001 12073 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** April Libby 17, 2004 8:45P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Evergreen Arden Court Potomac Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 🖾 F 577-70-6391 Director March 1. 1918 Washington, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Itema 23s or 28s-f ahow 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Mudical Exercitive count be notified at 1X Yes 2 No Directo Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3113 Worthington Street N.W. United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify White Specify: 3 → Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ng most of working al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John F. Carlson Messenger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11568 Fenchurch Ct., Germantown, MD 20876 John Libby (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State Apriliate 20 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 5 permit. Page Department of Important: If any injury or Chesapeake Crematory 2004 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 22. Name and Address of Facility
Rapp Funeral And Cremation Services
933 Gist Avenue Silver Spring, MD 20910 Rapp Funeral And Cremation S 933 Gist Avenue Silver Sprin Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Peripheral Vascular Disease Years resulting in death) /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Line, of identifying Cause (Disease or injury that initiated events resulting in death) Last Years Due to (or as a consequence of): Examiner or Attanding Physician: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Be Completed by Physician/Medical detached for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 1 Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2X No Medical Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 🖾 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🔲 Homicide tX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated 29b. Signature and title of cedif 29c. License number 29d. Date signed (Month, Day, Year) D35792 April 19, 2004 ath (Item 23a) (Type, Print) 30. Name and address of pers Swaroop G. Rao, M.D.; 50 W. Edmonston Dr. #504, Rockville, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) APRIL 16,2004 4:20a ONO HEALY LESCURE 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE BROADMEAD COCKEYSVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Wonths Days Hours Min. ULY 8, 1 9. Birthplace (State or Foreign Country) 1903WASHINGTOND • C 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1□M **X**[XF 100 215-48-7312 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes Ž∰No COCKEYSVILLE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 13801 YORK ROAD 21030 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 10 No If Yes, Give Year or Dates: 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) HOMEMAKER Elementary/Secondary (0-12) OWN HOME College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HEALY ONO VICKERY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (9a. Informant's Name/Relationship (Type, Print) SON KENNEBUNKPORT ME 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 04/20/2004 PIKESVILLE, MD. NDBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DRUID RIDGE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 16924 YORK ROAD MONKTON, MD 21111 23a. Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 2 12 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?/ Yes 2.2 No 2 No 1 Yes 1 Yes 25. Was case referred o medical examiner?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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or itams 23a

"natural",

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if item 27 is marked other than

permit. Pages 1 Department of H Important: if its any injury or ot

filed within 72 hours after

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records,

Director

Funerai

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Completed

other traumatic event, the Medical Examiner must be notified at

and the attending physician a ned for use as the burial-

Examiner Physician/Medical þ Completed Be 2 27. Manner of Death Certification:

Medical

IE FEMALE: 23b. Was decedent pregnant

1 ☐ Yes 2 ☑ No

5 Pending

investigation

6 Could not be determined

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 - Homicide

26. Place a eath Check onl one Other: 4 Jursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signaturand title of certifier 29c. License number

2 ER/Outpatient 3 DOA

28b. Time of

1 Inpatient 28a. Date of Injury (Month, Day Year)

30. Name and address of person who completed cause of death (Item 13a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

within 24 hours a To the Funarai L ro the Hospital

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) APRIL 16, 2004 **Physician** RANDY STEVEN LeVINE 3:50P. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City, Town, or Location of Death **Examiner** If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Sant. 3, 1 TOWSON BALTIMORE 519 EPSOM ROAD 1-C If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1∭M 2□F 49 216-66-9233 Yrs. 1954 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County in than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Marvland Baltimore Director Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 519 Epsom Road 21286 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. o filed within 72 hours after I Hygiene. other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: δ 3 ☐ Widowed 4 🂢 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4or 5+) Painter Home Improvement 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or othar traumatic avani LeVine Marvin Joseph Helen Lenore McCorison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maureen LeVine 6418 Loch Crest Road Baltimore, Maryland 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State
'4 □ Donation 5 □ Other (Specify) 4-20-04 Baltimore, Maryland Cardens of Faith Cemetery Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 21. Signature of Funeral Service Licenses Verraise Lev 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Atherosclerotic cardiorascular desease /Medical Due to (or as a consequence of): Examiner Secuentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence on: Examiner attending physician and for use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 4☐Pregnant at time of death ed by the a detached f certificate has been signed by rector, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? 1 X Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify SCENE 1XYes 2 □ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) and manner stated. ţ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. APRIL 17, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) r 111 Penn Street, Baltimore, Maryland 21201 M.D ondera 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 1 2004 boarks Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 6:55_{DM} **Physician** RUTH MERKEL APRIL 2004 VIRGINIA 15, /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctors Community Hospital Lanham Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 10 M 20 F 88 Yrs. 577-01-5027 Dec. 2, 1915 Director Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in then "natural", or Items 23s or 28s-f show the Medical Exercitive must be notified at 1 Yes 2 □ No Maryland Prince George's Brentwood Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3606 39th Avenue 20722 United States death Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 within filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife own home 12 permit. Pages 1 and 2 should be filed to Department of Health and Mentat Hygic Important: If item 27 is marked other any injury or other traumatic event, III. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Thomas Lee Rollins Mary Jane Sampson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9306 Merkel Farm Rd. Bowie, Maryland 20715 George Merkel, Sr. -son Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 4/19/2004 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, P.A. Dorald U. Ba 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Cardiomyopathy **Physician** /Medical Due to (or as a consequence of): Examiner Severe Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner use as the burial-transit and Due to (or as a consequence of): the attending physician 68760 Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. à 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 XNo funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Xinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division 5 Pending Injury 1 X Natural 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A death. investigation 2 Accident 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 within 24 hours a To the Funeral [To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D08520 April 16, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas J. Hernandez, M.D. 7525 Greenway Center Dr., T-6 Greenbelt, Maryland 20770 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

			For State Registrar		State of M	arylan		artment o				R	eg. No.	004	12077
	Physicia		1. Decedent's Name (First, I	Aiddle, Last)			MAG	ck			_ N	ate of Deat Month PR/L	h Day	Year Zeo4	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not inst.	tution, give :	# # m	SPIT	AL		BALT	-1moi	NE		4c. C	ounty of Deatl	n
	Funeral Director		5. Social Security Number A5.56.2535		7. A	ge (In yrs. i	(ast birthday) Yrs.	If Under 1 Months [Under 24 H ours Mi	in. (#	nate of Birth Month, Day, -15-19	Year)	9. Birtl	nplace (State or Foreign untry) NC
	faryland show	ō	Usuel Residence of Decede 10a. State 10b. Co				y, Town or Lo	_							10d. Inside City Limits 1 Yes 2 No
	with the N a or 28e-1 ibe natifi	Direct	10e. Street and Number		AVENUE			10f. Zip C	215			1		on of What Co	untry?
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23a or 28a-f show important: If item 27 is marked other than "neturel", or items 23a or 28a-f show amy injury or other traumetic event, I'm Madical Examinar must be natified at once.	by Funeral Director	11. Marital Status 1 Never Married 22 3 Widowed 4 Divi	Married	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	t Ever in U. No		Was Deceder f Yes, specify	t of Hispa Cuban, M	nic Origin? lexican, Pu	(Specify erto Ricar	Yes or No- n, etc.)	14	Race - Ame Black, White	
Maryland 21215-0036	filed within 72 hor Hygiene. Ither than "neture ant, the Modical I	Completed	15. Dec (Specify only) Elementary/Secondary (0 12 TH GOADE	12)	cation le completed) College (1-4or	5+)	(Give	dent's Usual (kind of work DO NOT use	doné durin retired)	ng most of w	working			of Business/	
/land	should be file nd Mental Hyg s marked othe umetic event,	To Be C	17. Father's Name (First, M.	ddle, Last) ù	WK				m	ARIE	Su				
	and 2 sho lealth and m 27 is mu		19a. Informant's Name/Rela PERRY MACK	tionship (T)	/pe, Print)		5316	CORDE	LIA			TO. 11	no	Town, State, 2 21215	
Baltimore,	Pages 1 and of He		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Crema 1 ☐ Donation 5 ☐ Ott			9 0	Place of Disponentery, creation	sition (Name	of		Date		20c. Loca	ation - City or SVIUE	Town, State
Baltii	permit. Pag Department Important: any injury o		21. Signature of Funeral Se			_		Name and LUGHN (151 BA)	Address of						
	Physician /Medical		23a. Part1. Enfer the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	se, or comp List only o	lications that cause ne cause on each a. Due to (or a	H	HODGK	er the mode	of dying, s	uch as card	liac or res	piratory arr	est,		Approximate Interval Between Onset and Death
,160,	te be executed by ysician and be burial-transit	ical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	b. Due to (or a Due to (or a d.										
P.O. Box 68	iries that the death certificate be executed signed by the attending physician and deedeched for use as the buriat-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 □ Yes 2 ☑ No 9 □ Unknown	nt	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fete	I death 3	∃Ectopic preg ∃ Other (spec					23	d. Date of del	ivery Day Year
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Divisi	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	Certification;	3 ☐ Suicide 6 ☐ 0	Could not be determined	286. Place of	njury - At h etc. <i>(Speci</i> i	ome, farm, st fy)	reet, factory,	office		28f. I	Location (S City or Tow	treet and n, State)	Number or Ru	iral Route Number,
	e Hospit 24 hour. e Funere etely fille	edical (29a. Certifier 1 🗹 Ce (Check only 2 🗋 Me	rtifying Phy dical Exam	ysician: To the bearing: On the basis and manner	of examina	owledge, deat ation and/or in	th occurred at evestigation, in	the time, my opini	date and pla on, death or	ace, and o	due to the c t the time, d	ause(s) a late and p	nd manner as place, and due	stated. to the cause(s)
	To the vithin To the comple	Me	29b. Signature and title of	certifier	0				icense nu				/	signed (Mont	
	2		30. Name and address of p	erson who	completed cause o	death (Ite	m 23a) (Type	Print)	U3	027	2		4/1	more,	7
_			THOMAS	5.	MILLER			Stron	ns	HOSP	ITA	L !	BALTI	more,	MO.
	St Regist	ate	31. Date filed (Month, Day,	Year) 2004	22. Regi	strar's Sign	ature	Spark	2						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month Year **Physician** MONROE, SR. 530 AM THOMAS E. 2004 /Medical 4a. Facility Name (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1400 RIGGS AVENUE BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10XM 2□F 218 18 0900 8 Director 07/20 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other treumatic event, the Medical Examinational Percentilled at any injury or other treumatic event, the Medical Examination of bottles. 10a State 1 XYes 2 □ No MD BALTIMORE **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. RIGGS AVENUE 21211 140D 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) STEEL CONDUCTOR 11th grade 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) DOROTHY MONROE THOMAS JOHNSON 2 Thomas Monroe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1400 RIGGS AVENUE BALTIMORE MD M. MUNROE ANNIE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

■ Burial 2

□ Cremation 3

□ Removal from State BALTIMORE, MD 2/04 WOODLAWN * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility VAUETHAL SERVICES 5151 BALTIMORE NATIONAL PIKE BALTIMORE MD 212291 am Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head ailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) metastatio prostate cancer Pnysician unknown /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transit Due to (or as a consequence of): cal Physician/Medi use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy sate has been signed by the atterpage 2 should be detached for it Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Colon cancer Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No certificate has 1 Yes 2 No ho-81funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 Z No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: al or Attending F after death. I Director: After After Injury 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide o the Hospitel 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 24 hor To the Fune completely fi

State Registrar

1

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR 2 1 2004

E. TSO MID

Se MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richer Hospice

32. Registrar's Signatur

838 N. Entaw St

D24170

29d. Date signed (Month, Dav. Year)

April 19, 2004

Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Roger B. Madden Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Roger В. Madden 1200 p /Medical April 20 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chesapeake Bay 1 mile from Love Point Stevensville Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0 Month Pay 1 9 16 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 215-84-8051 1 X M 2 □ F 42 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "neturel", or items 23e or 28a-f show traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No Director Md. Anne Arundel Pasadena 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 663 Pine Dr. 21122 USA Funeral or Items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Service Marine Boating 12 should be filed with and Mental Hygien 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Madden Thomas Ε. Norma White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tra (Spouse) Susan Madden 663 Pine Dr. Pasadena, Md. 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 Cremation 3 □ Removal from State 4/21/04 * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, Md. 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122 23a. Part 1. Enter the disease, or con shock, or heart failure. List only that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-tran Due to (or as a consequence of) attending physician P.O. Box 68760 Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ļo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1

Yes 2 □ No 24a Wasan Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Ves 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4□ Nursing Home 5□ Residence 6 ②Other (Specify) at SCENE 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury e Hospital or Attending P 24 hours after death. e Funerel Director: After ti Certification: 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 No investigation February 29, 2004 1125 AM Location (Street and Number or Rural Route Number, City or Town, State) Main Channellay I mile 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide chesipete Bu from Love Point, Anne Armille To the Hospital of within 24 hours at To the Funerel D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Surging Figure 11 in the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Machine Proposition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)?

and manner stated. Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, OCME April 21, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 THEVOORE

Registrar

2004

32 Registrar's Signature

31. Date filed (Month, Day, Year)

		-	State of Maryland / State of Maryland / State of Maryland / Per FH, G831, 5/4/2	Department of Health and I	Mental Hygie	ne2004	2080
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	ms 23	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No-	14. Race - American In Black, White, etc.	idian,
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" or items 23s or 28s-f show important: If item 27 is marked other than "natural" or items 20s or 28s-f show any injury or other traumatic avent, the Medical Examinar must be notified at ance.	b	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🕱 No Specify:	o moan, sto.)	Specify: BLA(CK
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	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	Location					1	0d. Inside City Limits
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	3		30. Name and address of person who Shahab Siddiqui	/	death (Item 23a) (T			Pennsy	lvania A MD 217			
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	Regist		APR 2 1 2004	General	19	Spork	2	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** 2004 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A 1105717AL SECOURS Birthplace (State or Foreign
Country) If Under 24 Hrs Date of Birth (Month, Day, Jan 20, 6. Sex 7. Age (In yrs, last birthday) 5. Social Security Number **Funeral** Hours 1 □ M 2X F Months Maryland 83 212-18-7888 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If lens 71 is marked other then "natural", or hame "near the market other then "natural". 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County Baltimore 1 Yes 2 No N/A Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 1004 N. Calhoun Street 21217 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. Black δ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Baltimore City** Elementary/Secondary (0-12) College (1-4or 5+) **Domestic Relations** 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Daisey J. Smith William H. Smith 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1004 N. Calhoun Street Baltimore, Maryland 21217 Michael E. McDaniels 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 04/21/04 Landsdown, Maryland Mt. Zion * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Esteo Brothers Funeral Home P.A. 1300 Eutaw Place Baltimore, MD 21217 Q.C. 1 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Myverdin Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PERTINSIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Du (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performed 2 No 1 Yes or Attending Physician: director. 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 P/Outpatient 3 DOA Medical Certification: To this npletely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 5 Pending 2 No death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

Division within 24 hours after death To the Funerel Director: To the Hospitel

> State Registrar

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DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

1,05

29b. Signature and title of certiller

GALL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

List Belt nurt wa) -BM SECOUR 016 32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D00156

29d. Date signed (Month, Day, Year)

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}	Examin	er	4a. Facility Name (If not institution,		_		4b. City, Town, or				ty of Death		
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			Usual Residence of Decedent		24		1	L	January	29 1910	IWasii.	rugton	. D . U .
	nylan how		10a. State 10b. County		10c. Cit	y, Town or Lo	ecation				1	10d. Inside C	•
	Ba-fa	cto		tgomery			I	Bethesda	1			1 L Yes	2 💢 No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cou	ntry?	
	ath w		5601_D	urbin Road				20814				States	3
	er de Itams	Funeral	11. Marital Status	12. Was Decede	s?	.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Ha Bla	ice - Americ ack, White,		
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21215-0036	d within 72 hours after death with the Maryland Jiene. r than "natural", or Itams 23a or 28a-f ahow The Medical Evantiner must be Indiffied at		15. Decedent's	Education		16a. Dece	dent's Usual Occup	ation		16b, Kind of E		hite dustry	
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pu	be filed ntal Hygi ad other evant, I	Be	17. Father's Name (First, Middle, La	est)				18. Mother's N	lame (First, Middle,	Maiden Suma	me)		
<u>Ia</u>	should by	To		David Mea	ade				Josep	hine Ba	ırbee		
Maryland	2 sho and Is my	. 9	19a. Informant's Name/Relationshi	(Type, Print)		19b. Maili	ng Address (Street	and Number or	Rural Route Numbe	er, City or Town	ı, State, Zip	Code)	
	s 1 and 2 should f Health and Men itam 27 Is marks othar traumatic	1	Richard K. Meade	/ Son	20h F			Road B	Bethesda,				
Baltimore,	Pages 1 all on the first in the first or other first or oth		20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3			emetery, crei	sition (Name of natory or other plac	Ap	Date ril	20c. Location	- City or 10	own, State	
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	/Medical		disease or condition resulting in death)		as a conseq	Lac Ari	est				-		
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	Y		30. Name and address of person w										
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	•	For State Registrar	State	of Ma	ryland		artmen tificate			and M	lental Hy	Reg. No	e 2(004	12081
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/Medic Examin	140	4a. Facility Name (If not institution,		umber)			4b. City,	Town, or	Location of	of Death			c. County	of Death	
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Funeral		,	. Sex 1 □ M 2 F	7. Age		ast birthday)	If Under Months		If Under	24 Hrs. Min.	8. Date of Bi	ay. Year	201	Count	ece (State or Foreign
Director		246-22-0461 Usual Residence of Decedent			79	Yrs.					June 4	, 19	24	Nort	h Carolina
and		10a. State 10b. County			10c. City	, Town or Lo	cation							10	Od. Inside City Limits
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To the Hospital or Attending Physician: The lymin 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the tuneral director, page	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ot be ned 28e. Pla	ace of Inju	ary - At ho :. (Specify	ome, farm, st	reet, factor	y, office			28f. Location City or To			er or Rurai	l Route Number,
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To th within To th comp	Me	29b. Signature and title of certifier)	.44	29	c. License	e number			29d. D	ate signed	d (Month, L	Day, Year)
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V		30. Name and address of person w								Roc	kville				0850
Sta Regist		31. Date filed (Month, Day, Year)	37	Registra	ar's Signa	ature 4	Spor								

	نالي		** State Registrar AMFND I'IFM #1 1. Decedent's Name (First, Middle, Las.	PER PHY C830	4/30/04 9i	ertificate of	Death	2. Date of De	aath	04 2085
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ı	Funeral Director		5. Social Security Number 6. Se 11 12 12 12 13 14 15 15 15 15 15 15 15 15 15 15 15 15 15	X 7. Age	(In yrs. last birthda 53 Yrs	Monthe Dave	If Under 24 Hr. Hours Min	. (Month, Da	th	Birthplace (State or Foreign Country) Maryland
	2 >	Ì	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or	Lanation				10d. Inside City Limits
:	a-f eho	ctor	Maryland Baltime	ore	Lanso					1 ☐ Yes 2 No
	Sa or 28	Funeral Director	10e. Street and Number 2423 Brunswick Rd			10f. Zip Code 21227			10g. Citizen of V	1
	ms 2;	era	11. Marital Status	12. Was Decedent E	ver in U.S. 1	3. Was Decedent of H	lispanic Origin? (Specify Yes or No		e - American Indian,
	uges I and 2 should be filed within 7.2 hours after bean with the maryanism of the fells and Mental Hygiene. If I feam 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic event, the Medical Examinar name the notified at		1 Never Married 2X Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 📉 N If Yes, Give Year or Dates:	0	If Yes, specify Cubing 1 ☐ Yes 2X No		rto Rican, etc.)	Specify	ck, White, etc. White
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2	d oth	Be	17. Father's Name (First, Middle, Last)					me (First, Middle		99)
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2	nt: # I		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 1 ☐ Donation 5 ☐ Other (Specify,			Crematory		19-04	Baltim	ore, MD
paitimore,	permit. Prages I and Department of Health Important: if Itam 27 any injury or other tr once.	Ì	21. Signature of Funeral Service Licens	see		22. Name and Addre				iore, in
<u> </u>	imp eny eny		Hopens	ter		1328 Sul	ohur Spr	ing Rd.	Arbutus	. MD. 21227
	hysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final			enter the mode of dyir	ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
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_	wrequires that the de been signed by the s should be detached	y Ph	Part II. Dther significant conditions co	ntributing to death bu	t not resulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco use contr	ibute to the cause of death?
3	en sig	ed b	Peripheral Vasc	ular Dise	ase			10	Yes 2□No	3 Probably 4 Unknown
ပ် 10 .	2 st b	plet	Duodenal Ulcer					24a. Was		Vere autopsy findings available irror to completion of cause of
בׁ =	pa	Com						perfo	rmed? d	leath? ☐ Yes 2√2 No
110	ertific Betor,	Be	25. Was case referred to medical examiner?	Unanital.		0.1		ath (Check only o	nne)	
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LO.	After funer	tlon	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injur	Wor	yan k? Yes 2 □No	28d. Describe	now injury occurre	90
Division of Vital	or Attending after death. Diractor: After in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ry - At home, farm, (Specify)	street, factory, office		28f. Location (S City or Tox		er or Rural Route Number,
	to the hospital of Attendin within 24 hours after death. To the Funeral Diractor: Aft completely filled in by the fur	edical C	29a. Certifier (Check only one) Certifying Phy	rsician: To the best of iner: On the basis of and manner stat	examination and/or	ath occurred at the tin investigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and mar date and place, a	nner as stated. and due to the cause(s)
	within To the	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed	(Month, Dey, Year)
	4		Dr. Anitua	Nollu		P17	599		04-16-0	04
	10		30. Name and address of person who c St. Agnes Health	ompleted cause of de		-	1+4	MD 03	300	
			ot. Agnes nealth	Lare 900	, a. Cato	n ave. Ba	ltimore,	MD . 21	.229	

DHMH 17 Rev 1/2001

ORIGINAL

			. For	State of Ma						iene			
			1 - State Registrar		(Certificat	e of Deat	h		-	004	1208	16
	Physicia	an	Decedent's Name (First, Middle, Last,						2. Date of Deat Month	Day	Yeer	3. Time of Death	м
	/Medic	al	ELIZABETH A. NE 4a. Fecility Name (If not institution, give		-	4h City	Town, or Locatio	on of Death	APRIL	4c. County	2004 of Death	7:40 P	
	Examin	er	MARINER HEALTH		т нтіл.		REST HI				RFORD		
	Funeral		5. Social Security Number 6. Sec	x 7. Age	(In yrs. last birth		1 Year If Und	der 24 Hrs.	8. Date of Birth (Month, Day,			ece (State or Foreig	gn
	Director		210 14 1175]м 2ҚО ғ	79 Y	rs. Moritins	Days	S IVIIII.	May 2,	1924	Mary	land	
and	*		Usuel Residence of Decedent 10a, State 10b, County		10c. City, Town	or Location					10	d. Inside City Limit	is
Mary	f sho	jo	Maryland Harford		Bel A	Air						1∭Yes 2□N	.0
the	r 28a	irec	10e. Street and Number			10f. Zip	Code		1	0g. Citizen of	What Coun	try?	
GELETICOCOCOCOCOCOCOCOCOCOCOCOCOCOCOCOCOCOCO	al', or items 23a or 28a-f show Examinat musi be notified at	Funeral Director	126 N. Hickory Ave	enue Apt	28		1014			USA			
r dea	tems ar m	ner	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Dece If Yes, spe	dent of Hispanic (cify Cuban, Mexic	Origin? (Spe can, Puerto l	cify Yes or No- Rican, etc.)		ce - America ck, White, e		
s afte	lo.	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎇 Divorced	1 ☐ Yes 2 📉 N If Yes, Give Year or Dates:	10	1 🗆 Yes	2∑ No Speci	eity:		Specif	y: Whi	te	
P Por	atura Gal E		15. Decedent's Edu	ucation	16a. [Decedent's Usu	al Occupation	nost of working	20	16b. Kind of B			
hin Z	e may	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5	+)		ork done during m se retired)	lost of workii	ng				
1 N	ygien f. Esth	Con	12			Clerk_	10.140	thada Nama	(First, Middle, M			ernment	
	ed oth	Be	17. Father's Name (First, Middle, Last) Joseph Cornel:	ius Mo	ore			izabet		Ionoria		Fitzpatri	ick
should be	in marked other than	ဥ	19a. Informant's Name/Relationship (T			Mailing Addres	s (Street and Nun						
3, 1VIC	5 - 5		Philip Nelson - So		126	5 N. Hi	ckory Av	renue 7	Apt 28,	Bel Ai	r, MD	21014	
, ע	Item 27		20a. Method of Disposition 1 Surial 2 Cremation 3 1	Domayal from State	20b. Place of I cemetery	Disposition (Na., crematory or	me of other place)		ate	20c. Location	- City or To	wn, State	
	ant: If		* 4 □ Donation 5 □ Other (Specify,)	Bel Ai		Gardens	4/19,		Bel Ai			
משונ	point rayes fair Department of Heali Important: If Item 2 any injury or other once.		21. Signalure of Funeral Service Lizens	ma L	/		nd Address of Fa • Broadw		Comas F			•	
	10 = 10		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that gaused	the death. Do no			_	•			Approximate	
_	hisisas		Immediate Cause (Final	ine cause on each lin								Interval Between Onset and Death	
	hysician /Medical		disease or condition resulting in death)	a. Due to (or as	a consequence of	leereter f):	pulu	one	same	-			-
Ε	xaminer		Sequentially list conditions	b									
5	z iz	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of	f):							
ou,	and and ii-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of	f):							
		caiE		d									
00	The law requires that his bean beinneare are has been signed by the attending phys bage 2 should be detached for use as the	ledic	15.555										
מאַ	tendir tendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic p					ate of delive	ry Day Year	
ָה בּיל בּיל	the at	Physician/Medi	1 Yes 2 No	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 Other (s	oecify)						
7	ed by detac	/ Ph	Part II. Other significant conditions co	ontributing to death b	ut not resulting in	the underlying	cause given in Pa	art I.	23e. Did tol	bacco use con	tribute to th	e cause of death?	
Vital Records,	n sign Ild be	d by							in	es 2□No	3 🗌 Prob	ably 4 □Unknov	vn
0	s bee 2 short	piete							24a. Was a		Were autop	osy findings availab	ole
ן אַנּ	ate ha	Completed							perform	ned?	death?	2 No	
/IIa	ertific actor,	Be (25. Was case referred to medicat examiner?	Hospital:					(Check only on				
10	this cral dir	٦.	1 Yes 2 No	1 🗀 Inpatre	ont 2 ER/Out		OA 4 28c. Injury at		me 5 Reside			′)	
ם ו	th. : After	tion	Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Day	y Year) In	jury M	Work? 1 ☐ Yes 2	2 □No					
DIVISION	Attended of the py the	ertification:	3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, far	m, street, facto	ry, office		28f. Location (St City or Town		ber or Rura	l Route Number,	
5	rs after rel Dir	Cer									<u>-</u>		
	to the Hospital of Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Medical		ysician: To the best niner: On the basis of and manner sta	examination and								
	o the	Med	29b. Signature and title of certifier	4.10.114.110.010		29	c. License numb)er	2	9d. Date signe	ed (Month,	Day, Year)	
,	- > - 0		Dand 5	2			032	255		Op-:	111.	2004	
	6		30. Name and address of person who o										
	_	oto.	DAVID S. DUNN 31. Date filed (Month, Day, Year)		MACPHAIL ar's Signature			, PIARI		014			
	Sta Regist	ate rar	ADD 9 1 2004	Leker	- /	Spa	Ks						

			1 - For State Registrar	State of Marylan		artment of I		F	10g. No. 20	14 12087
	Physici /Medio	cal	1. Decedent's Name (First, Middle, Last) WILLIAM OTS OLI 4a. Fecility Name (If not institution, give s	VER		4h Cihi Tour	or Location of Deat	2. Date of Dea Month	2004 Ye	3. Time of Death 4-05 A M
	Examir	ier		MURSING HO		BALTIM If Under 1 Year	ORE			Ala
	Funeral Director			M 2□F 83	Yrs.	Months Days	Hours Min.	(Month, Day	Year) GIG	Birthplace (State or Foreign Country)
	e Maryland Ba-f show	ctor	10a. State 10b. County NA		y, Town or Lo					10d. Inside City Limits 1 Ø Yes 2 □ No
	ath with the 23a or 2	Funeral Director	100. Street and Number 1111 PARK AVE.	1602		10f. Zip Code 21201			10g. Citizen of Wha	t Country?
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinational be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ÑNo If Yes, Give Year or Dates:		Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2 🗷 No	Hispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	Black, V	American Indian, Vhite, etc. BLACK
21215-(filed within 72 h Hygiene. other than "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12 TH GRADE	cation completed) College (1-4or 5+)	(Give	DO NOT use retire	during most of wo	rking	16b. Kind of Busine	
Maryland 2121	should be filed and Mental Hyg s marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) OTIS OLIVIER				MARY &	TACKSON	Ü	
	1 and 2 sho Health and Iem 27 is mo		19a. Informant's Name/Relationship (Ty) CORDELIA DLIVER 20a Mathad of Disposition	2	1111		and Number or Ru VE # 160	12, BAL		21201
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 【2 Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, crem	OUNT	04.2	2-04	20c. Location - City BALTO , N	
Ba	Depar Impo		21. Signature of Funeral Service Licent			51 BALTO.		IKE, B	ALTO: MI	
	Physician /Medical Examiner		23a. Pan1. Enter the Asease, or compli- shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Due to (or as a consequence)	brove	me mode or dyn	Accide	e or respiratory arr	est,	Approximate Interval Between Onset and Death
8760,	certificate be executed ding physician and ise as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ						
O. Box 6	death certific e attending p id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetel 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of Month	delivery Day Year
rds, P.	The law requires that the te has been signed by th vage 2 should be detache	by	Part II. Other significant conditions con Didbites Mulin							e to the cause of death? Probably 4 Munknown
al Reco		Completed	Didbetes Melita Nyjertension					24a. Was a autops perform 1 Yes 2	y prior ned? death	autopsy findings available to completion of cause of ??
Division of Vital Records,	To the Hospitel or Attanding Physician: The within 24 hours alter death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	tlon; To Be	27. Manner of Death 1 (2)Natural 5 Pending	ospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. injur Wor	er: 4 Mursing H		e) once 6 Other (S ow injury occurred	pecify)
DIVISI	To the Hospitel or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At ho building, etc. (Specify	me, farm, stre		100 20110	28f. Location (St. City or Town	reet and Number or n. State)	Rural Route Number,
	he Hospit in 24 hours he Funera pletely fille	lical	one) 2 Medical Examin	ician: To the best of my knower: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my o	pinion, death occu	rred at the time, da	ate and place, and o	lue to the cause(s)
	To t To t	2	29b. Signature and title of certifier Melouy 30. Name and address of person who DL. OCHANEJ 31. Date filed (Month, Day, Year) APR 2 1 2004	ND		29c. Licens	t052i	29	Pril 20,2	onth, Day, Year)
	7		30. Name and address of person who I r DK: OCHANEY	mpleted cause of death (Item	23a) (Type, i	Print) 3350 R-101K	Wilkens more, n	D 2122	q Suite	302
1	Sta Registr	te ar	APR 2 1 2004	. Registrar's Signat	199	parks				

		1 - Stete Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of r rtificate of			iene 2	004 120
		1. Decedent's Name (First, Middle, L	ast)				2. Date of Death Month	h Day	3. Time of Dea
Physicia		John Vincent (O'Brien				April		004 6:55 a
/Medic Examin		4a. Facility Name (If not institution, g			4b. City, Town, o	or Location of Death	APLIL	4c. County	
LXaiiiii	eı	Charlestown Care			Catons				
				(In yrs. last birthday			8 Date of Birth		timore
Funeral		063-12-4702	1 ⊠ M 2□F	88 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or For Country)
Director	1	Usual Residence of Decedent		80			Feb 15,	1916	New York
3	1	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Li
윺	5	Maryland Baltim	oro	•	sville				1 ☐ Yes 2√2
28a-f show notified at	Sc)re	Cator	isville				
or 2	Director	10e. Street and Number			10f. Zip Code		10	-	What Country?
23e	<u>ea</u>	719 Maiden Choic	ce Lane HR5	25	21228	3		United	l States
al', or items 23a or 28a-f shov Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Spann, Mexican, Puerto	ecity Yes or No-		e - American Indian,
or its	교	1 ☐ Never Married 2X Married		lo			ricari, etc./		ck, White, etc. White
5.9	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify	v: Willce
"natural",	Completed	15. Decedent's	Education	16a, Dece	edent's Usual Occur	pation	1	16b. Kind of Bu	usiness/Industry
c d	et	(Specify only highest g	rade completed)	(Give	kind of work done DO NOT use retired	nation during most of work d)	ing		,
than .	Ē	Elementary/Secondary (0-12)	College (1-4or 5	+)				7.4	
her it.	ပိ	17. Father's Name (First, Middle, Las	6_	V1	ce Presid				lvertising
d of	Be	James M. O'Brie				18. Mother's Name			10)
and Mental Hygiene. Is marked other than aumatic event, the Me	2	James M. O BLI	⇒111			Eller	O'Boyle	}	
DE E		19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Street	and Number or Rura	al Route Number,	City or Town,	State, Zip Code) 212:
27 I		Jessie B. O'Brie	en / Wife	719	Maiden Ch	oice Lane	HR 525	Cato	nsville, MD
Health tem 27 other tra		20a. Method of Disposition		20b. Place of Disp	osition (Name of				City or Town, State
or if it		1 ☐ Burial 2 X Cremation 3	Removal from State	1	matory or other place		104	D-1+3	WI
tmer tant jury		`4 □Donation 5 □ Other (Spec			Cremator				ore, Maryland
Department of Health and Mental Hygiene, Important: If item 27 Is marked other than 's any injury or other traumatic event, the Ma once.		21. Signature of Funeral Service Lic	ensee						Home, Inc. Maryland 212:
		22a Barti Estar the disease or se	malications that saved						Approximate
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	y one cause on each lin				or respiratory arre	51,	Interval Between Onset and Death
ysician		Immediate Cause (Final disease or condition		PY	lumen	lld			Oriset and Death
Medical		resulting in death)	Due to (or as a	a consequence of):					
aminer									
**************************************	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Constant of the cause of the cau	b. Due to (or as a	consequence of):					
usit	듣	cause. Enter Underlying							
sician and burial-transit	Examiner	resulting in death) Last	c. Due to (or as a	consequence of):					
sician a burial	cai E			,					
2 00	<u>20</u>		d						
attending phys for use as the	Physician/Medl	IF FEMALE:			-				
andi	5	23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth	of pregnancy	∃Ectopic pregnancy			23d. Date	e of delivery
d for	Ca	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at		Other (specify)			Mor	nth Day Year
y the	lys	9 Unknown	9□ Unknown						
ed by the detached	<u>a</u>	Part II. Other significant/conditions	contributing to death bu	t not resulting in the u	inderlying cause giv	en in Part I.	23e. Did toba	acco use contr	ribute to the cause of death
P e	Q	Pank	enson	deseas	l		1 ☐ Yes	- 14	3 ☐ Probably 4 ☐ Unkno
been should	ted	1 - 11 - 11		7	-		1 1 165	- 2/2(190	3 Probably 4 DORKIN
2 sh	Completed		lenson Hypi	rennet	H		24a. Was an		Were autopsy findings available
	E						autopsy perform	ed? d	prior to completion of cause leath?
ficat or, p		25 Was same referred to modical							☐Yes 2☐ No
is certificate he director, page	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death		-	
	2	1 Yes 2 No	1 🗆 Inpatier		nt 3L DOA	Nursing Hor	me 5 Resider		
	on:	27. Manner of Death 1. Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time o	Wor		28d. Describe hov	v injury occurre	ed
frer	ati	2 Accident investigati				Yes 2□No			
After funer	100	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 289. Place of Inju	ry - At home, farm, st	reet, factory, office	-	28f. Location (Stre	et and Numbe	er or Rural Route Number,
After funer		4 Tromcide	building, etc	. (Specify)			City or Town,	State)	
After funer	ert		hysician: To the best o	f my knowledge, deat	h occurred at the time	no date and place	and due to the on-	.0.0(a) and	
After funer	I Certification;	29a Contition 1/2 Contituing F	miner: On the basis of	examination and/or in	vestigation, in my o	pinion, death occurr	and due to the cat ed at the time, dat	ise(s) and mai le and place, a	nner as stated. and due to the cause(s)
After funer	ical Cert	29a. Certifier (Check only 2 Medical Exa		led .					
After funer	edical	(Check only 2 Medical Ext	and manner star						
Viter	edical	(Check only 2 Medical Exa	and manner star		29c Licens	e number	7 29	d. Date signed	(Month, Day, Year)
After funer	edical	(Check only 2 Medical Ext	and manner star		29c Licens	ZOO41	9 29	d. Date signed	(Month, Day, Year)
After funer	edical	29b. Signature and title of confider	M M		29c Licens	e number 20040	290	d. Date signed	(Month, Day, Year)
After funer	edical	29b. Signature and title of confider	and manner state and ma		Print)	number 20040 house Co	296 M. (d. Date signed	(Month, Day, Year) 17/04 USVILLE, M

			1 - For State Registrar	State of Maryland / Dep	artment of Health and I	- :	2001. 12001
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Las DE BO RAH) 4a. Facility Name (If not institution, give	PA	ZUNTY 4b. City, Town, or Location of Death	APRIL 1	ay Year 2004 12 09 A M
	Funeral	er Sije	HARBOR H 5. Social Security Number 6. S	OS PITAL 7. Age (In yrs. last birthday	BALTIMORE		N/A
۵	Director		212-58-8531 1 Usual Residence of Decedent 10a. State 10b. County	54 Yrs.		Sept. 24,	1949 Marÿland 10d. Inside City Limits
	h the Mary r 28e-f sho	Director	Maryland Anne A	rundel Balt	imore	10g. C	1 ☐ Yes 2X No itizen of What Country?
036	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28e-f show the Madical Examiner must be milliad at	by Funeral	3707 Pascal Ave. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	21226 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036		Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) (Givilife.	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired) Office Clerk	king	Kind of Business/Industry Mote1
yland 2		To Be C	17. Father's Name (First, Middle, Last) Gaspari	Scardina, S	18. Mother's Nam		. Barrett
	1 and Health em 27 ther tr		19a. Informant's Name/Relationship (S Michael Prunty (S 20a. Method of Disposition	5on) 773	ing Address (Street and Number or Ru 44 Woodlawn Ave. P osition (Name of imatory or other place)	asadena, Ma	
Baltimore,	permit. Pages Department of Important: If It Important: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifications) 21. Signature of Funeral Service Licer	Bayview	Crematory 4/19 Name and Address of Facility CCully-Polyniak F		altimore, Maryland
T	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the death. Do not en			Approximate Interval Between Onset and Death
	/Medical Examiner	if	resulting in death) Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):	CHINE ST	1 01201916	, days
1,092	ate be executed nysician and he burial-transit	cal Examiner	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):			<u> </u>
.O. Box 68	The law requires that the death certificat tie has been signed by the attending phy tage 2 should be detached for use as th	Physician/MedI	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
٩	quires that in signed by uld be deta	by	Part II. Other significant conditions o	ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Il Records,		Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 1 No
of Vital	Physicien: rthis certific ral director,	To Be	25. Was case referred to medical examiner? 1 Tyes 2 The No. 27. Manner of Death	Hospital: 1X Inpatient 2 ER/Outpatie 28a. Date of Injury 28b. Time of	ent 3 DOA Other: 4 Nursing H	th (Check only one) ome 5 Residence 28d. Describe how inju	
Division	l or Attending I after death. Director: After I in by the funer	Certification:	1 承Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		Work? M 1 ☐ Yes 2 ☐ No		nd Number or Rural Route Number,
۵	Hospita 4 hours Funerell ely fillec	edical Cer	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowledge, dea niner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place	and due to the cause(s	s) and manner as stated
)	To the within 2 To the complete	Med	29b. Signature and title of certifier	and mainer Stated.	29c. License number		ate signed (Month, Day, Year)
	P			completed cause of death (Item 23a) (Type		REET, B	ALTINORE MD
	Sta Registi		31. Date filed (Month, Day, Teal)	32. Registrar's Signature	porker		

			1 - For State Registrar			nd / Dep		of H	ealth a		ental Hy	giene	_	- 1	120	90
П	Physic	ian	Decedent's Name (First, Midd		E1	D					2. Date of De. Month	Da		Year	3. Time of D	
	/Medi	cal	An English Name (If not instituti	Albert		Pappan			Lassias	(5 - 15	April				9:05A	M
	Exami	ner	4a. Facility Name (If not institution Rockville Nur	-	iber)				Location o	of Death			. County			
	Funeral		5. Social Security Number	-	7. Age (In yrs.	last birthday)	If Under		If Under		8. Date of Birl (Month, Da	th .	Mont	9. Birthpl	y ace (State or I try)	Foreign
	Director		495-16-9722	1 ∑ M 2□F	93	Yrs.	Months	Days	Hours	Min.	Month, Da April 21	y, Year) 1	910	Ohic	try)	3
	and w		Usual Residence of Decedent 10a. State 10b. Count	<i>y</i>	10c. Cit	ty, Town or Lo	ocation							14	Od. Inside City	Limita
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	the Maryland r 28a-f ehow	rect	10e. Street and Number			100	10f. Zip (-		10g. Cit	tizen of W	/hat Coun	try?	
	within 72 hours after death with the Maryland sne, "natural;" or Items 23s or 28s-f show the Medical Exam har mat be invitted at	Funeral Director	303 Adclare Ro	ad				20	0850						States	
	r dea	mer	11. Marital Status	12. Was Deced	dent Ever in U	.S. 13.	Was Decede	nt of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race	- America	an Indian,	
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Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service		ROC						14	wası	ı Tilğ (on,	р.с.	
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,1760,	death certificate be executed e attending physician and identificate as the burial-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Each of the cause (Disease or injury that initiated events resulting in death) Last	b. Due to (o	ebrovas ras a conseq ertensi ras a conseq ras a conseq	uence of): .ON uence of):	Accid	ent								
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of Vital	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 🌠 No	Hospital: 1 🗆 In	patient 2	ER/Outpatien	t 3 DOA	Other	~		e 5 Reside		6 DOther	(Specify)		
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Division	al or Atte s after de al Diracto	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Place C	f Injury - At ho g, etc. <i>(Specif</i> y	ome, farm, str	eet, factory,	office		28	3f. Location (Si City or Town	treet and n, State,	d Numbei }	or Rural	Route Number	;
	To the Hospital or Attent within 24 hours after death To the Funeral Diractor: completely filled in by the	Medical (29a. Certifier 1 Certifyi. (Check only one)	ng Physician: To the b Examiner: On the bas and manne	is of examinat	wledge, death tion and/or inv	occurred at restigation, in	the time	a, date and nion, death	place, ar	nd due to the c d at the time, d	ause(s) ate and	and man place, ar	ner as sta id due to t	ted. he cause(s)	
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	Sta Registi		31. Date filed (Month, Day, Year, APR 2 1 2		gistrar's Signa		Span	621								

State of Maryland / Department of Health and Mental Hygiene 2004 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** TMANDA April 4:5/A.M 2004 OWEI /Medical 4c. County of Death N 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number reen 000 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 M.D. **Funeral** 214 18 7512 1 □ M 2 Ø F Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at M.D 1 Yes 2 No Completed by Funeral Director BA Homes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 2/212 115 EAST AV E MELLOSE "natural', or itema 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 25 No Specify Specify: Black 3 ₩idowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ଞ tath 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CLARK 9 GASFINS JAMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) BAHIMORY MO JEffer MI Charles 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot cemetery, crematory or other place, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial 4 ☐ Donation 5 ☐ Other (Specify) April 22,2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BEHS FuneRAL Tatucia Duto 57 BATTIMONG MD N. CARGLINE Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** edon van /Medical Due to (or as a consequence of): Examiner brase Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a con equence of): Division of Vital Records, P.O. Box 68760 the attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy lor in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ de 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 2 40 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director; After this campletely filled in by the funeral director. 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of Injury 1 Natural 5 Pending 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only To the 29c. License number 29b. Signature and title of ceptitie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balf. mD 2)2) H 308 31. Date filed (Month, Day, Year) 32. Registrar' Signature State APR 2 1 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 12092 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4a. Facility Name (If not institution, give street and number) APRIL 19,2004 Quattrocchi 9 **‡** 00a [™] /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE

If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Anoths Days Hours Min. Month, Day, Year)

MAY 19, 15 511 S. POTOMAC STREET N/A 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 12XM 2□F 69 Yrs. 219-30-4345 Director 1934 MARYLAND Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23a or 28e-f show the Mudical Examiner must be notified at XXYes 2 □ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? POTOMAC 511 S. STREET 21224 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. e filed within 72 hours after de al Hygiene. other than "naturel", or Item 1 ☐ Yes 2 ☐ No It Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Importent: If Item 27 is marked other tha any injury or other traumatic event, Item ance. 11 LABORER ALLIED CHEMICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ANDREA QUATTROCCHI JENNIE LANZA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 511 S. POTOMAC STREET, BALTIMORE, MD. MILDRED CATOR-QUATTROCCHI 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OAK LAWN CEMETERY 4/22/04 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTO., MD. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Obedine Chronic /Medical Due to (or as a consequence of): Examiner Asbestosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Talmutato Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 Yes 2 No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🔀 No ٩ this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending 1 ☐ Yes 2 ☐ No Director: / 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funerel D completely filled it 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) M.0 00055171 4/19/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEBASTIAN JOHN 3023 MO 21224 EASTERN AVENUE BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 2 1 2004

			For State Registrar	State of		nd / Depa	artmen	t of H		and M	lental Hy	giene	2004	12093
	Physici	an	1. Decedent's Name (First, Middle, L.	ast)							2. Date of De. Month April	ath		3. Time of Death
	/Media		Mary	Agne			Robe		1	4 D 4 h	April	_	2004	0415 AM M
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	Funeral		Social Security Number 6.	Sex 7	Age (In yrs.	last birthday)	If Under	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birt	h V Year	9. Birti	hplece (State or Foreign
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	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or La	cation							10d. Inside City Limits
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	or 28	Director	10e. Street and Number				10f. Zip	Code 0815					n of What Co	
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39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than *natural', or items 23a or 28a-1 show any injury or other traumatic event, it is Medical Examiner must be notified at Once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 【★ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1 Tes 2 If Yes, Give Year or Date	es? XNo	1	Yes, spec			n, Puerto	ecify Yes or No Rican, etc.)		Black, White	e, etc.
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<u>lan</u>	Aentai Aentai rked c	ToB	James	Conway					Ida	ı	Mas	son		
Maryland 21215-0036	aith and N		19a. Informant's Name/Relationship Alvin Mars F	(Type, Print) Roberts /H	lusband	19b. Mailin 817	g Address E. Fr	(Street a ank1	in Av	enue	A Route Number, Silv	r.CityorT ver Sp	own, State, Z	ip Code) MD 20901
Baltimore,	Pages 1 and nent of He ant: If Item ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Spec		210	Place of Dispo cemetery, cren nesapea	natory or o	ther place			-2004		tion - City or I sville	
3alt	ermit. Departr nport ny inj		21. Signature of Funeral Service Ince	nsee 2	14003	82 R	. Name an app F	^{d Addres} uner	s of Facility a1 An	id Cr	emation	Serv	ices	
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Вох	attenc for us	clany	23b. Was decedent pregnant in the past 12 months?		me or pregna n 2 □ Feta nt at time of d	Ideath 3□	Ectopic pr					230	I. Date of deli- Month	very Day Year
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Division of Vital Records,	or Attending Physician: after death. Director: After this certifici in by the funeral director, in	on: T	27. Manner of Death 1	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	2	Bc. Injury Work			28d. Describe h			
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$\overline{\underline{N}}$	i or Attendated after deatler: Director:	Certification:	4 Homicide determined		, etc. (Specif	ome, farm, stre	et, ractory	, omice		1	City or Tow		Unider or Hui	al Route Number,
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			> Volkpanel	pman	-7 M	· D.		D276	560			Apri	1 16,	2004
	10		30. Name and address of person who					D 4 1	G		100 5	1		00050
	Sta	te	Alpana Goswam, 31. Date filed (Month, Day, Year)	32. Reg	11119 istrar's Signa	KOCKVI	гтте	rıke	Suit	e G-	100 Roc	KVIII	e, MD	20852
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						ORIGINA	AL.							

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death .Physician , 200L ANINA B. RIDEOUT /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NA MERCY BALTIMORE AT MARIS STELLA | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (2 1 0) 4/13/04 AT 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1 M 28 F 216.42.0219 Yrs. Director MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show armen of Health and Mantal Hygiene. ortant: if Item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumstic event, the Medical Examiner must be notified at NIA 1 N Yes 2 No **Funeral Director** MO BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1000 DRULDON 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent Ever in U,S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 MM 1 ☐ Yes 2 K No Specify: Specify: BLACK Be Completed by 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSES AIDE 11 TH GRADE HEALTH NA 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) SIDEOU7 Pages 1 and 2 should be nent of Health and Mantal ALEVANDER DAVIS MARTHA BAXTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if Item 27 is m any injury or other traum 516 W. PRESTON ST. JANIE BENNET BALTO. MD 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) MT- ZION 04.24.04 BALTU, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTU. NATL PIKE BALTU. MO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he art bailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the bunal-transit or Attending Physician: The law requires that the death certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 8 Probably 4 □ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2/11/10 1 Yes 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica complataly filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Comer (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 2 No 1 Tes investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 - Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 40854 1004 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 1 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** TYRONE ROGERS 13 APRIL 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner landallstown BALTIMORE HOSPITA NORTHWEST If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1**⊠**M 2□F Months 21796 097 3 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State in then "neturel", or items 23a or 28e-f ehow the Medical Examinar must be notified at N/A MD 1 XYes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 Favelle 2596 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give/ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 ie marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) _ABOR 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ANNIE CONTER ROGERS DANIEL. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 ie
eny injury or other treu 2596 W. Favelle Street Ballimore MD2123 sheila Kogers 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 04/20/04 Randallstown, MD 1 Surial 2 Cremation 3 Removal from State KING PARK * 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility
VAMOHN C. GREENE FINERAL SERVICES
5151 Baltimore National PIKE Baltimore MD 21229
Approximate 21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760 the attending physician Physician/Medical the as 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐ Yes , 2 ☐ No Records, P.O. 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown RENAL FAILURE Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 X No Division of Vital or Attending Physicien; after death. Director: After this certifica 25. Was case referred to medical examiner?
1 ☐ Yes 2 ★ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation М 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel o within 24 hours aft To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

MORTH WEST

31. Date filed (Month, Day, Year) APR 2 1 2004

HOSPITAL CENTER 32. Registrar's Signature oaks

Mille m.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JoGINDER PMEHTA

41410

RANDAUS TOWN MO

APRIL 13

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 10:45 PM **Physician** Linda S. Rider APRIL 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UNIVERSITY BALTIMORE DF MARYLAND # Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year June 26, n/a
9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 6. 1943 Alabama **Funeral** 1 □ M 25 F 60 Yrs. 218-38-3594 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 te marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1√2 Yes 2 No Director Maryland n/a BAltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 610 South Monroe Street 21223 Funeral death Race - American Indian. Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Beautician Beauty Salon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental F ed bluods George Wilkinson <u>Velma Smith</u> 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 le any injury or other trai Pages 1 and 2 Arthur L. Rider 610 South Monroe Street, Baltimore, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 21 Baltimore, MD 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. Pant. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 21229 Approximate Interval Between Onset and Death 23a. Part 1. Immediate Cause (Final disease or condition resulting in death) SEDSIS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury ner Due to (or as a consequence of) that the death certificate be executed Exam that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) physician by Physician/Medical the use as t IF FEMALE ff yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy for u Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform certificate 1 ☐ Yes 2**0** No 1 ☐ Yes 2 ☐ No of Vital director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 22 No 2 this After thi 28a. Date of Injury (Month, Day Year) Manner of Death
1 DNatural
2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. the within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 44417643515740 John mil ala-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S GREENE ST, Baltimore, MD Sharmeel Wasan, University of Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 1 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene? [] [] [

Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month **Physician** 8:20 A^M REMSBERG APRIL 17 2004 RAMONA CORUN /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sep 3, 1928 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6 Sax **Funeral** Min Days Hours 1 □ M 2 K F 75 Yrs. 213-24-9458 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County or Items 23a or 28a-f show the Medical Examiner must be notified at Frederick Frederick Maryland 1 X Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 816 Shawnee Drive 21701 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ∐Yes 2 ☑ No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: δ 3 ₩ Widowed 4 Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Banker Financial Institution 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importaet: If item 27 is marked othe any linjury or other treumatic event once. Be Corun W Alonzo Susie Crampton ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alicia R. Buxton / Niece 2728 Jennings Chapel Rd, Woodbine, Maryland 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Reformed Cemetery Apr 22, 2004 * 4 ☐ Donation 5 ☐ Other (Specify) Jefferson, Maryland 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home
106 East Church St, Frederick, Maryland 21701 21. Signature of Funeral Service Licensee M00706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METHETHIC COCON CANGER 2 YEARS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 2 No 1□ Yes 2√No 1 TYes Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 6 Other (Specify) o 28c. injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death 28b. Time of 5 Pending investigation To the Hospital or Attending Division 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No Director: / 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D31761 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 40 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 2 1 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of M	laryland		artment of rtificate o		nd Mental Hy	Reg. No. 20	04 12098
H	Physicia /Medic	al	1. Decedent's Name (First, Middle, Arthur 4a. Facility Name (If not institution,	Ε.		aum	4h City Town	or Location of	2. Date of Do Month 04/18	Day	3. Time of Death 6:45 P M
	Examina Funeral	3	Charlotte Hall	Veterans H		st birthday) Yrs.		tte Hal	.1	St. M	ary s 9. Birthplace (State or Foreign Country)
	Director **Brown 1 1 1 1 1 1 1 1 1	tor	Usuel Residence of Decedent 10a. State 10b. County Maryland Prince	George's	10c. City,	Town or Lo	cation nington		12/19/	1921	Maryland 10d. Inside City Limits 1 🗆 Yes 203000
	er death with the Items 23a or 28a	Funeral Director	10e. Street and Number 11013 Rivervie 11. Marital Status	12. Was Deceden Armed Forces	7 10	i. 13.		20744	n? (Specify Yes or N Puerto Rican, etc.)	10g. Citizen of Wh USA o- 14. Race Black,	-
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at	n 72 hours afte	Completed by F	1 Never Married 2 Marrie 3 Widowed 4 12 12 Norced 15. Decedent: (Specify only highest	If Yes, Give Year or Dates: Education grade completed)	1945	16a. Dece	dent's Usual Occ	upation	of working	Specify:	White iness/Industry
	d be filed withing the filed withing the filed other than cevent, the M	Be	College (1-4or 5+) Carpenter 12								Government
	1 and 2 shouk Health and Me em 27 Is mark ther treumati	To	19a. Informant's Name/Relationsh Tracy A. Raum / 20a. Method of Disposition	p (Type, Print)	20b. Pla	11013	B Rivery	iew Roa	or Rural Route Numb	per, City or Town, S	Maryland 20744
Baltimore,	permit. Pages Department of I mportant: If it any injury or o		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp. 21. Signatur 1 Funeral Service)	ecify)		as Cro	matory or other penatory Ematory 2. Name and Ado	4/: lress of Facility	20/04 P Kalas	Edgewate	r, Maryland
į.	Physician		23a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition	complications that cause only one cause on each	line.	Do not ent		ying, such as ca			Approximate Interval Between Onset and Death
	death certificate be executed many earliereding physician and dor use as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a b Due to (or a c. Due to (or a d.	s a conseque	ence of):					
		by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	∃Ectopic pregnar ∃Other (specify)	ncy		23d. Date Monti	
Records, P.	The law requires that the tie has been signed by thoage 2 should be detache	ted by Ph	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobac DD STAGE RENTAL DISEASE, HYRERTENSION, 1 Yes								ute to the cause of death?
		Se Completed	ANEMIA PER 25. Was case referred to medical	HEART TA	Ascus	osinosan na	ATKIM SEXSE,	DIABETE	J24a. Was auto perf 1 Yes of Death (Check only	ormed? de	ere autopsy findings available or to completion of cause of ath?
Division of V	aling Phys	ation: To B	examiner? 1 Yes 2 No 27. Mannar of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of In (Month, D	ient 2 □ E ury ay Year)	P/Outpatier 28b. Time o Injury	f 28c. In			idence 6 Other how injury occurred	
Divis	oital or Attendi urs after death orel Director: A illed in by the f	Certification:	2 Accident 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f.						City or To	wn, State)	or Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical	29a. Certifier (Check only one) 2 Medical E 29b. Si nature and title of certifier	Physician: To the bes xaminer: On the basis and manner s	of examinati	viedge, deat on and/or in	vestigation, in m	time, date and opinion, death	place, and due to the occurred at the time,	cause(s) and mann date and place, an 29d. Date signed (d due to the cause(s)
•	6		30. Name and address of person v	ho completed cause of	death (Item	23a) (Type,	Print)	5096	3	04/19/	2004
	J	te	FUCTON LUK 31. Date file many 1. Days Your	BAN M.D.	CH kar's Signati	eVH,	CHAR	्राह्म	HALL LA	1D	

State of Maryland / Department of Health and Mental Hygiene 1

	1	For State Registrar				tificate of L			Reg. No.	ا 12099		
sician edical		Deborah	, Ann		ter/			2. Date of Dea Month	/13/04			
miner	4	a. Facility Name (If not institution		ole Hall Road		4b. City, Town, or		imore	4c. County of D	N/A		
ral tor		Social Security Number 212-70-7184	6. Sex 1 □ M 2 X	15	s. last birthday) 17 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	y, Year) , 1956	Birthplece (State or Foreign Country) Maryland		
1	1	Jsual Residence of Decedent 0a. State 10b. Count Maryland	n/A	10c. (City, Town or Lo		ıltimore			10d. Inside City Limits		
Direct	1	0e. Street and Number 4608 Marble Hall R				10f. Zip Code	21239		-	Og. Citizen of What Country? U.S.A.		
ones. To Re Completed by Funeral Director	1	1. Marital Status 1 Never Married 2 Marital Status 3 Widowed 4 Divorce	12. Was Armed 1	Decedent Ever in ed Forces? Yes 2 XNo is, Give r or Dates:		Was Decedent of Hi f Yes, specify Cubar 1 Yes 2 XNo		Americen Indian, Vhite, etc. Black				
Completed	hered		ent's Education nest grade comple		16a. Dece (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired, Hom	16b. Kind of Busine	ess/Industry Home				
To Be Co	1	7. Father's Name (First, Middle	e, Last) milton Roys	ster			18. Mother's Na		Maiden Sumame) llie Royster			
F	-	19a. Informant's Name/Relation		t)		ng Address (Street a				, City or Town, State, Zip Code)		
	- 2	20a. Method of Disposition 1 3 Burial 2 Cremation 4 Donation 5 Other	n 3 🗌 Removal		. Place of Dispo cemetery, crea	osition (Name of matory or other place Mt. Zion	θ)	Date 04/17/04	20c. Location - City Landsdo	or Town, State		
OUCE.		21. Signature of Fune al Service	ce Licensee	540	22	2. Name and Addres Estep B		eral Home P Baltimore, M	A. D 21217			
in i		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Alvaced (err.; at CA) CEN Due to (or as a consequence of):										
2												
Fyaminer	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d c	ue to (or as a cons	equence of):	-				12 years		
Framiner	alcai	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c d	ue to (or as a cons	gnancy etal death 35	□Ectopic pregnancy			23d. Date of Month	delivery Day Year		
hy Ohiololan/Modical Evaminer	by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2	c	ue to (or as a consue to (or a consue to	gnancy etal death 30 death 50	□Ectopic pregnancy □ Other (specify)	en in Part I.		Month			
hy Obygolan/Modical Evaminer	by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c	ue to (or as a consue to (or a consue to	gnancy etal death 30 death 50	□Ectopic pregnancy □ Other (specify)	en in Part I.	1 🗆 '	Month obacco use contribu Yes 2 \[\sum No 3 \] an 24b. Wer prior graph deat	Day Year te to the cause of death? Probably 4 Unknown e autopsy findings available to completion of cause of		
To Do O complete the Ohio Cale (Modern Evample)	To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c	ue to (or as a consue to (or as a consue to (or as a consue to con	gnancy etal death 3 [resulting in the use of the sequence of	□Ectopic pregnancy □ Other (specify) Inderlying cause give at 3□ DOA □ Other 28c. Injunt World	26. Place of De er: 4 ☐ Nursing / at (?	24a. Was autopento 1 Tyes wath (Check only of Home 5 - Resident)	Month obacco use contribu Yes 2 \(\text{No} \) No 3[an 24b. Wer prior prior prior deat 1]	Day Year te to the cause of death? Probably 4 Unknown e autopsy findings available to completion of cause of th? Yes 2 No		
To Do Complete by Dhydlalan/Madical Evaminar	To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c	ue to (or as a consue to (or as a consue to (or as a consue s. outcome of predictive birth 2 F. Pregnant at time of Unknown g to death but not a consue to the consue to	grancy etal death 3[stresulting in the unit of death 5 [stresulting in the unit of	□Ectopic pregnancy □ Other (specify) □ Inderlying cause give int 3□ DOA Other if 28c. Injun Worl M 1□	26. Place of De er: 4 \(\) Nursing	24a. Was autop performed to the control of the cont	Month obacco use contribu Yes 2 No 3 an	Day Year te to the cause of death? Probably 4 Unknown e autopsy findings available to completion of cause of th? Yes 2 No		
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the state of the s	To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c	ue to (or as a consue to (or as	gnancy etal death 35 of death 55 or seventing in the unit of the seventing in the seventing in the unit of the seventing in the seventing	DOA Other (specify) onto 3 DOA Other (specify) onto 4 DO	26. Place of De er: 4 Nursing / at k? Yes 2 No ne, date and place	24a. Was autoperformed at the time,	Month obacco use contribution Yes 2 \(\text{No} \) 3 \(\text{an} \) an 24b. Wer prior deat 1 \(\text{cone} \) one) dence 6 \(\text{Other} \) (the winjury occurred Street and Number own, State) cause(s) and manned date and place, and	Day Year te to the cause of death? Probably 4 Unknown e autopsy findings available to completion of cause of th? Yes 2 No Specify) Prayal Route Number, or as stated. due to the cause(s)		

DHMH 17 Rev 1/2001

Registrar

		-	For State Registrar	State of Ma		epartme Certifica			Mental Hy	giene Reg. No. 2	004	12100	
	Physicia	49	Decedent's Name (First, Middle, Last) Lloyd	Vaughn	Schro				2. Date of D Month April		Year	3. Time of Death	
>	/Medic Examin		4a. Facility Name (If not institution, give s Holy Cross Hospit	treet and number)	Schie	4b. Cit		Location of Dea	ith	4c. Co	2004 unty of Death ontgome		
	Funeral Director		1/3-20-6/03	7. Age	(In yrs. last birth 77 Y		ler 1 Year s Days	If Under 24 Hr. Hours Min	1. (Month, D	irth ay, Year) 5, 192	Cou	plece (State or Foreign ntry) 1sylvania	
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome		10c. City, Town		Silver Spring				10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
	with the	i Direc	10e. Street and Number 10904 Bucknell Dr	#1123		10f. i	Zip Code	10.2	10g. Citizen of What C				
altimore, Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event. The Madical Examiner must be inclined at once.	by Funeral Director		12. Was Decedent E Armed Forces? 1 Myes 2 No If Yes, Give Year or Dates:					Specify Yes or N rto Rican, etc.)	0- 14.	Race - Ameri Black, White,	can Indian,	
	within 72 hou ene. then "neture be Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)		16a. [Decedent's Us Give kind of life. DO NOT	work done d use retired	furing most of we)	orking		of Business/In	rernment	
	td be filed ental Hygi ked other ic event, t	To Be Co	17. Father's Name (First, Middle, Last) Lloyd	Sch	cock			18. Mother's Na Anna	ame (First, Middle K	e, Maiden Sur Cenda11			
	nd 2 shoullith and M 27 is mar	 -	19a. Informant's Name/Relationship (Ty) Joan H. Schrock /			-			#1123, S			Code) MD 20902	
	Peges 1 a nent of Heis nt: If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of I cometery Chesape	crematory o	r other plac	Apr	Date 11 20,		ion - City or To	own, Stete	
Balti	permit. I Departm Importer any inju		21. Signature of Funeral Service Lioshse		100382				Crematic lver Spr	n Serv	ices		
All was	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Cardio	n orespira	tory A	ode of dyin	g, such as cardia				Approximate Interval Between Onset and Death	
	/Medical Examiner	er	Sequentially list conditions	Myoca	consequence of rdial In	farcti	Lon					1 hour	
0,0	death certificate be executed e attending physicien and nd for use as the burial-transit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Arter:		tic Ca	ırdiov	ascular	Disease	2		20 years	
68760,	tificate b ig physic as the bi	ledical		nyper	Lension								
P.O. Box		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)						23d.	Date of delive Month	ery Day Year	
	es De	by	Part II. Other significant conditions cor Diabetes Melli			the underlyin	g cause give	en in Part I.))	tobacco use o		he cause of death?	
Vital Records,	The law requir ate has been si page 2 should	Completed	Ulcerative Col	itis	ltis				24a. Wa auto pen 1 Yes	opsy formed?	4b. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of	
Vita	Physicien: this certifica ral director, p	Be	25. Was case referred to medical examiner?	lospital:	_		DOA Othe	200	eath (Check only				
o	ling After Tune	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatier 28a. Date of Injun (Month, Day	t 2 🔀 ER/Out / 28b. Ti // 28b. Ti		28c. Injun Work	4 Hursing	Home 5 ☐ Res 28d. Describe			(y)	
Division	E E E	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc.	ry - At home, fam (Specify)	n, street, fact	ory, office			(Street and Nown, State)	umber or Rur	al Route Number,	
	e Hospitel 24 hours a e Funerel letely filled	edical (sician: To the best oner: On the basis of and manner state	examination and								
)	To the Hosi within 24 ho To the Func completely f	Me	29b. Signature and title of certifier	the second	(12)		D280				gned (Month,		
	3		30. Name and address of ferson who co Leszek J. Fiutow				lle Dr	., Coll	ege Park	, MD	20740		
A.	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 1 2004	32 Registra	r's Signature	ko	Dente of						

DHMH 17 Rev 1/2001

Registrar

APR 2 1 2004

		•	For State Registrar	State	of Maryland / D	epartment of Certificate o			giene Reg. No. 2004	12102	
	Physici		1. Decedent's Name (First, Middle					2. Date of Dea Month	ath Day Year	3. Time of Death	
	/Medic	al .	Ruth		3.	Smith		April	18 2004	0431 M	
	Examin	er	4a. Facility Name (If not institutio				n, or Location of Deat	h	4c. County of Death		
	-		Anne Arunde1 : 5. Social Security Number	Medical C	7. Age (In yrs. last birth	Annaj dav) If Under 1 Ye		8. Date of Birt	Anne Aru	nde1 place (State or Foreign intry)	
	Funeral Director		474-03-0884	1 □ M 20X F	97 Y	Months Da	ys Hours Min.	Jan. 3		nesota	
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Logotion					
	shov	5	,	Arunde1	Annaj					10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If Health and Mental Hygiene with a factorial sor 1 is marked other than "natural", or thams 23e or 28a-f show it am 27 is marked other than "natural", or than 23e or 28a-f show other traumatic evant, the Medical Examination until but an additional	ect	10e. Street and Number		Aima	10f, Zip Cod	e		10g. Citizen of What Cou	intro?	
	3e or	Funeral Director	800 Bestgate	Road			21401		USA		
	ms 2	nera	11. Marital Status	12. Was De	ecedent Ever in U.S. Forces?	13. Was Decedent	of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No-			
9	after or Ita	F.	1 ☐ Never Married 2 ☐ Mar	ried 1 Tyes	s 2.XINo	1 ☐ Yes 2X 1		to Rican, etc.)		hite	
21215-0036	72 hours after death with the Maryland natural', or Itams 23e or 28a-f show liteal Expriment : ust be motified at	d by	3 X Widowed 4 □ Divorced	Year or	Dates:	Decedent's Usual Oc					
15-	in 72 i "nat	Completed	(Specify only highe		d) (Give kind of work do life. DO NOT use rei	ne during most of wo	rking	16b. Kind of Business/li	loustry	
212	filed within Hygiene. other than "	шо	Elementary/Secondary (0-12)	College	(1-4or 5+) Adr	ninistrati	ive Assist	ant	U.S. Gover	nment	
	e filed al Hygid other vant, L	BeC	17. Father's Name (First, Middle,	Last)			18. Mother's Na	me (First, Middle,	Maiden Sumame)		
Maryland	should be ind Mental marked o umatic eve	To	Robert Lee Bro					ugustine			
lar.	2 sho		19a. Informant's Name/Relations						or, City or Town, State, Zi	p Code)	
	1 and 2 Health tam 27		Mary Lou Bond 20a. Method of Disposition	(Daugnte	20b. Place of I	Disposition (Name of	f !	, Duluth	MN 55804 20c. Location - City or T	own. State	
Baltimore,	nit. Page artment o ortant: If injury or		1XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		m State cemetery	, crematory or other	place)	2/2004			
Ē			21. Signature of Funeral Service		Lakelioi	22. Name and Ad			Davidsonvil.	Le, MD	
B	permi Depa Impo any ir		13- J. (Jun		Hardest	y Funeral	Home, P	.A. olis, MD 21/	401	
	*		23a. Part1. Enter the disease, of shock, or heart failure. Lis	r coloplications that t only one cause or	t caused the death. Do no	ot enter the mode of	dying, such as cardia	c or respiratory ar	rest,	Approximate Interval Between	
	Priysician		Immediate Cause (Final disease or condition	a	myocardial	intarct	ron			Onset and Death	
	/Medical Examiner		resulting in death)	Due t	to (or is a consequence of):					
	Lxammer	_	Sequentially list conditions,	b. Due t	to or as a consequence of	ή.					
	uted 1 Insit	nln	Cause (Disease or injury	<	10 to a solid, 1 and 5						
Ć,	execun n and ial-tra	Examine	that initiated events resulting in death) Last	c	to (or as a consequence of):					
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit			d							
9	leath certifica attending ph I for use as th	Physician/Medical	IF FEMALE:								
Box	ath ce ttendi or use	lan/l	23b. Was decedent pregnant in the past 12 months?	1 Live	outcome of pregnancy e birth 2 Fetal death	3 □Ectopic pregna			23d. Date of delive	very Day Year	
0	he de the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pre 9□Uni	gnant at time of death known	5 Other (specify	"				
٥	res that the d signed by the be detached	y Ph	Part II. Other significant condit	ions contributing to	death but not resulting in	the underlying cause	given in Part I.	23e. Did to	bacco use contribute to	the cause of death?	
Records,	quires n sigr ald be	ed by						1 🗆 Y	∕es 2□No 3□Pro	bably 4 Minnown	
00	aw requir is been si 2 should	olete						24a. Was	an 24b. Were aut	opsy findings available	
	The law	Completed							rmed? death?	ompletion of cause of	
Vital	ılcian: Th certificete rector, pag	BeC	25. Was case referred to medical examiner?	-			26. Place of De	ath (Check only o			
of V	Physician: this certific ral director,	P	1 Yes 2 No		Inpatient 2 ER/Out	Dalibili 3LI DOA		-	lence 6 Other (Speci	fy)	
o uc	ding P	lon:	27. Manner of Death 1 ☐ Hatural 5 ☐ Pendi	119	te of Injury onth, Day Year) 28b. Ti		njury at Work? 1 □ Yes 2 □ No	28d. Describe h	low injury occurred		
Division	Attending ir death. actor: After by the fune	icat	3 Suicide 6 Could		ace of Injury - At home, far			28f. Location (S	Street and Number or Rur	al Route Number.	
Div	after Dirac	Certification;	4 Homicide	mined 209. Fis	ilding, etc. (Specify)	.,,,,,,		City or Tow	m, State)		
_	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funaral Director: After this certificate his completely filled in by the funeral director, page				the best of my knowledge,						
	he Ho in 24 he Fu	Medical	(Check only 2 Medica one)		a basis of examination and anner stated.						
	To T To I	Σ	29b. Signature and title of certifi	er A			ense number		29d. Date signed (Month,	Day, Year)	
•	10		Mutan Tr	le mu	<i>)</i>		18809		April 18,04		
	/		104 Ridgely	to A	nuse of death (Item 23a) (I	1214	,		,		
:	Sta Regist	ate rar	31. Date filed (Month, Day, Year		. Registrar's Signature	Sone	61				
	riegist	3 4	APR 2 1	(004 /~	1	The same	-				

	For State C	of Maryland / Depa Cer	artment of Health and M ctificate of Death	lental Hygier	
Physician	Decedent's Name (First, Middle, Last) HENRY JACO	B STOLL JR.		2. Date of Death Month APRIL 18	2004 Year 12:00 M
/Medical Examiner	Facility Name (If not institution, give street and not 724 OLD RIVERSIDE ROAD	imber)	4b. City, Town, or Location of Death Baltimore	1	4c. County of Death Anne Arundel Co.
Funeral Director	Social Security Number 6. Sex 1 M M 2□ F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Sept. 14	9. Birthplace (State or Foreign Country) Maryland
death with the Maryland rims 23e or 28e-1 show result for indifficial at more all Director	a. State 10b. County Md. Anne Arundel C	o. 10c. City, Town or Lo		* *.	10d. Inside City Limits 1 ☐ Yes 2¾☐ No
so or 28a-1 st	e. Street and Number 724 Old Riverside Roa	d	10f. Zip Code 21225	10g. (Citizen of What Country? U.S.A.
hours after death v fural; or items 23 Examiner most	Armed F	orces? 2 □ No ive	Nas Decedent of Hispanic Origin? (Sp if Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🏋 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
within 72 ene. then "nei	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) 10 College	(Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired) ager	G G	Kind of Business/Industry unnings rab House
And be filed Mental Hyginarked other attc svent,	Father's Name (First, Middle, Last) Henry Jacob Stoll Sr.			(First, Middle, Maid Oceak	
d 2 should be file th and Mental Hy 7 is merked oth traumatic svent	9a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Rum Old Riverside Road		
- 25 N L	Lula Stoll (Wi)a. Method of Disposition 1 ∰ Burial 2 □ Cremation 3 □ Removal fron 14 □ Donation 5 □ Other (Specify)	20b. Place of Dispo	20 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Date 20c.	Location - City or Town, State kridge, Md.
permit. Pages 1 a Department of Hee Important: If item any injury or othe	1. Signature of Funeral Service Ligensee		2. Name and Address of Facility McCully—Polynial 237 E. Patapsco	. Funeral	
The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the law representation and in the law representation in the	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury nat initiated events c.	1 1	denocareiman		Interval Between Onset and Death Unlknum
nat the death certific	in the past 12 morths?	gnant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
uires that the de	art II. Other significant conditions contributing to		23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ ₩nknown		
ician: The law requir certificate has been si ector, page 2 should				24a. Was an autopsy performed 1 ☐ Yes 2 ☑	
Physician: rthis certifical director,	7. Manner of Death 28a. Dat	Inpatient 2 ER/Outpatien e of Injury onth, Day Year) 28b. Time of Injury	nt 3 DOA Other: 4 Nursing Ho	th (Check only one) ime 5 km esidence 28d. Describe how in	6 ⊡Other (Specify) njury occurred
To the Hospital or Atlanding P within 24 hours after death. To the Funaral Director: After the Completely filled in by the funeral Director.	3 Suicide 6 Could not be determined 28e. Pla	ce of Injury · At home, farm, st ding, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
To the Hospital within 24 hours a To the Funaral I completely filled	(Check only 2 Medical Examiner: On the	basis of examination and/or in	th occurred at the time, date and place, ivestigation, in my opinion, death occur	red at the time, date a	and place, and due to the cause(s)
To the withing To the comp	19b. Signature and title of certifier		29c. License number 022782	29d.	Date signed (Month, Day, Year)
5+1	10. Name and address of person who completed ca	use of death (Item 23a) (Type	Print) Of South Herave	street B	Date signed (Month, Day, Year) 11/19, 2004 althour, Manyland 2122
Stat Registra		Registrar's Signature	Sports		

William G. Smith 04-02649 crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

204		-	For State Registrer	State of Ma		artment of artificate o		nd Mental Hy	O S.No. 20	04 12104	
	Physici /Medic		1. Decedent's Name <i>(First, Middl</i> e, Las William	•	ith			2. Date of Do		3. Time of Death 8:59 P M	
	Examin		4a. Fecility Name (If not institution, give North Arundel Ho			4b. City, Town Glen E			Anne	4c. County of Death Anne Arundel	
	Funeral Director		213-36-4333	ex 7. Age	(In yrs. last birthday 52 Yrs.	Months Day		Min. 8. Date of Bi	^{rth} , 1951	9. Birthplace (State or Foreign Mar yland	
	death with the Maryland ms 23a or 28a-f show rmust be notified at	Director	Usual Residence of Decedent	Arundel	10c. City, Town or t				10g Citizen of N	10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	72 hours after "neturel", or Ita	I Dir	1858 Potomac Roa	d		Toi. Zip Code	21122			g. Citizen of What Country? U.S.A.	
Baltimore, Maryland 21215-0036		by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	Ever in U.S. 13	Was Decedent of If Yes, specify Co		in? (Specify Yes or N Puerto Rican, etc.)		e - American Indian, ek, White, etc. ~ White	
		Completed	15. Decedent's Economic (Specify only highest grade) Elementary/Secondary (0-12) 1.2		+) (Giv	edent's Usual Occ e kind of work dor DO NOT use reti Supervis	ne during most ired)	of working		usiness/Industry ting Company	
	al Hyg I othar	Be	17. Father's Name (First, Middle, Last, Walton Louis		1	ouper vis	18. Mothe	r's Name (First, Middle Ruth Ange:	, Maiden Sumam		
aryla	es 1 and 2 should be fi of Health and Mantal F f item 27 is marked ot ir othar traumatic ever	L L	19a. Informant's Name/Relationship (et and Numbe	r or Rural Route Numb	per, City or Town,		
€, ₩	and ealth n 27		Cathy D. Smith	(Wife)	185		c Road	, Pasadena		nd 21122 City or Town, State	
Baltimore	Pag nent ent: I		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Bay view	ematory or other p	·	4-20-04		re, Maryland	
	permit. Departn Importe any inju		21. Signature of Feneral Service Lice	Ramm	1	Name and Add McCully- 3204 Mou	ress of Facility Polynia Intain	ak Funeral Road,Pasad	Home P.	A. yland 21122	
8760,	Medical /Medical Examiner	dical Examiner	23a. Part1. Enter the disease, or com shock, or heart lailure. List only limediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (pisease or injury that initiated events resulting in death) Last	b. Due to (or as a c.	a consequence of):		yng, 5001 ab	and an or respiratory v		Approximate Interval Batween Onset and Death	
P.O. Box 68	The law requires that the death certificate be exacuted ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnal			23d. Dat Mo	e ol delivery nth Day Year	
ds, P.	uires that the signed by Id be detacted	d by Ph	Part II. Other significant conditions	contributing to death bu	ut not resulting in the	underlying cause	given in Part I.		tobacco use conti Yes 2 No	ribute to the cause of death? 3 Probably 4 Unknown	
of Vital Records,	; The law require cate has been sig , page 2 should t	Complete						24a. Wa. auto perf 1 Pes	s an 24b. No 1	Nere autopsy findings available prior to completion of cause of leach?	
Vita	ysicien; The l is certificate he director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 XER/Outpati	ent 3 DOA	7thor	of Death (Check only sing Home 5 Res		er (Specify)	
Division of	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director, is	Certification; T	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injur (Month, Day	Year) 28b. Time Injury	ol 28c. In V M 1	jury at Vork? □ Yes 2 ☐ 1	28d. Describe DRIVEN	how injury occurr	orcycle impact	
Divi	Hospital or At 24 hours after of Funerel Directely filled in by		4 Homicide determined	vsicien: To the hest	ury - At home, larm, s c. (Specify)	ath occurred at the	time date and	Ha MAIN	D NRVENT	nner as stated.	
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	(Check only 2 Medicel Exe	miner: On the basis of	examination and/or	investigation, in m	y opinion, deat	h occurred at the time	, date and place,	and due to the cause(s)	
	To the within 2 To the Complete	M	29b. Signature and title of certifier	me Yhu	le		O.C.M.	Ε.	April 18	1 (Month, Day, Year) 3 , 2004	
	p,		30. Name and address of person who MAIZCOMD A.	Completed cause of d	. 4	Penn Str		altimore, 1	Maryland	21201	
ь	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 1 2004	32. Registra	ar's Signatur	Sporks	,				

		1	For State Registrar	State of Ma			it of Health and e of Death		iene 19. No. 2004	12105
	Physicia	ın	1. Decedent's Name (First, Middle, La Thomas	Michael		Sylves	ter	2. Date of Death Month 04/17/	n 2004 Year	3. Time of Death 7:40 PM
2	/Medic Examin	-	a. Fecility Name (If not institution, giv 2012 Browns Lane				Town, or Location of De . Washingto		4c. County of Deeth Prince Ge	
	Funeral Director		5. Social Security Number 6. S		e (In yrs. last birt 69	hday) If Unde Months	r 1 Year If Under 24 H Days Hours Mi			place (State or Foreign Intry) Panama
	he Maryland 8a-f show cuttied at		Usual Residence of Decedent 10a. State 10b. County Maryland Prince (10e. Street and Number	George's	10c. City, Towr	or Location • Washi		11	0g. Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 No
	y within 72 hours after death with the Maryland jiens r then antural; or Itams 23s or 28s-f show the Marical Examination matical redilited at	raiDi	2012 Browns Lane	12. Was Decedent Armed Forces?	Everin U.S. Retire	207		(Specify Yes or No-	USA 14. Race - Amer Black, While	ican Indian, , etc.
Maryland 21215-0036	72 hours afte natural', or li ulcel Examin	þ	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gr			1 ☑ Yes Decedent's Usu (Give kind of we	al Occupation		Specify: 16b. Kind of Business/le	Black
	be filed within tal Hygiene. d other then event, the Max	e Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Lasi	College (1-4or	5+)	Adminis	trator	lame (First, Middle, M	Amtrak Maiden Sumame)	
rylan	be d la	To Be	Michael Sylves		19b	Mailing Addres	Rose F		, City or Town, State, Z	ip Code)
	es 1 and 2 s of Health an of tiem 27 is or other trau		Graciela Sylvest 20a. Method of Disposition 1 Burial 2 Cremation 3 [Removal from State	20b. Place of cemeter	Disposition (Na y, crematory or	rns Lane Ft.	Date	20c. Location - City or 1	Town, State
Baltimore,	permit. Peg Department Important: I eny injury c	ĺ	21. Signature Funeral Service Lice		1	22. Name a	nd Address of Eacility Early & Oxon Hill Ro	P. Kalas	Funeral Ho	ome P.A.
100	Pnysician /Medical Examiner	ler	23a: Part. Enter the disease, or cor stock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Due to for as	ine.	cell	de of dying, such as card		est.	Approximate Interval Between Onset and Death 3 m on the
8760,	cate be executed obysician and the burial-transit	cal Examine	cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	cDue to (or as	s a consequence	of):				
.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 Fetal death at time of death	3 □Ectopic 5 □ Other (s			23d. Date of deli Month	very D <i>a</i> y Year
Q	w requires that to be the signed by should be detailed	by	Part II. Dther significant conditions	contributing to death	bul not resulting i	n the underlying	cause given in Part I.	23e. Did tol	bacco use contribute to es 2 No 3 □ Pro	the cause of death?
Il Records,	The law re cate has bee page 2 sho	Completed						24a. Was a autops perford 1 ☐ Yes	an 24b. Were au prior to death? 2 No 1 Yes	topsy findings available completion of cause of
Vital	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital:			Other	Death (Check only or		
of	ng fter	tion; To	1 Yes 2 No 27. Manner of Death 1 Nalural 5 Pending investigate	28a. Date of Inj (Month, D		Itpatient 3 C Time of njury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		ence 6 Other (Specow injury occurred	any)
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical Certification;	2 Accident Investigation 3 Suicide 6 Could not determine	be 28e. Place of Ir	njury - At home, fa etc. (Specify)	arm, street, facto	ory, office	28f. Location (S. City or Town	treet and Number or Ru n, State)	ıral Route Number,
	Hospite 24 hours Funerel letely filled	dical C	29a. Certifier 1 Certifying F (Check only one)	Physician: To the bes aminer: On the basis and manners	of examination ar	e, death occurre	d at the time, date and pl on, in my opinion, death o	ace, and due to the c ccurred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	1 All	imeE		9c. License number $0.5 - 8$	72	APRIL	19 2004
_	10		30. Name and address of person who	eez, Do.		(Type, Print) (WALTER RE- 6900 GEORGIA WASHINGTON	AVE DC 2	0307	I EK
	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 1 20	4	trar's Signature	5 de	alls.	*		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 1+ 10A.M. **Physician** Mamie M. Snyder 2004 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner 11 more Jaure ranklin +tospi +AL If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🛛 F Months 74 03/27/1930 Director 208-22-5580 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madicial Eventure in that be notified at once. 1 ☐ Yes 2X No Funeral Director Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10005 Crane Lane 21220 U.S.A. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Snyder, MAMI Specify: Specify: ģ White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) 10 Shopping Mall Housekeeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Raymond H. Rehriq Katie E. Nunamaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Tomelis (sister) 1100 Orchard Drive - White Hall, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) St. Michael's Luth. Cem. 04/21/2004 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Be Completed by Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of Division of Vital Records, P.O. Box 68760, IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 MNo 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy ō 5 Other (specify) 4☐Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 D No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 1 Yes 2 🗆 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Unpatient Medical Certification; To 1 ☐ Yes 2 ER/Outpatient 3□ DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred atural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗑 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 8 D0058671 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D

State Registrar

31. Date filed (Month, Day, Year) APR 2 1 2004

Jon Tilburt

D.

5415 SPLINGLAKE WAY, BALTIMORE, MO 32. Registrar's Signature

			1 - For State Registrar	State of Marylar		tment of F			ene 20	04 12107
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give sign) Authority Communication (If not institution) Authority Communication (If not institution)	Marion Dolore			r Location of Death	2. Date of Death Month April	Day 7 20 4c. County o	3. Time of Death 2 2 30 AM f Death
ς	Funeral Director		Usual Residence of Decedent	7/Age (In yrs.) M 2025 67		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 26	Year)	9. Birthplace (State or Foreign Country) Maryland
solotes	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	Funeral Director	10a. State 10b. County Maryland N/A 10e. Street and Number		ity, Town or Loca			10	g. Citizen of Wr	10d. Inside City Limits 1 🖫 Yes 2 □ No nat Country?
7	ath with	raiD	1406 Popland Str			212			U.S.	
Maríon 5-0036	ours after de raf', or items Examiner m	Ď	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Y	as Decedent of H Yes, specify Cuba	ispanic Origin? (Spec an, Mexican, Puerto F Specify:	ify Yes or No- lican, etc.)	Black	- American Indian, White, etc. White
M; 215-0	hin 72 h n "natu Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Deceder (Give kir life. DC	nt's Usual Occup nd of work done o NOT use retired	ation during most of workin d)	g 1	6b. Kind of Bus	iness/Industry
7	led with lygiene her the nt, lite		8th	College (19401 34)	Asse	embly Wo				Bindery
welge Marvland	ges 1 and 2 should be filed within to the Health and Mental Hygiene. If item 27 is marked other than or other traumatic evant, tra M.	To Be	17. Father's Name (First, Middle, Last) William 19a. Informant's Name/Relationship (Ty,		19h Mailing	Address /Street	18. Mother's Name Kath and Number or Rural	erine B	arrett	
	lith ar 27 is		Joseph Schweiger			opland				yland 21226
J Ch	Pages 1 and ment of Health ant: if item 27 ury or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ XOther (Specify)		Place of Disposit cemetery, crema Cedar Hi					ity or Town, State
Balt			21. Signature of Funeral Service License		22. 1	lame and Addres		ce Fune	ral Ser	vice, P.A. Maryland 21225
•	Physician /Medical Examiner	ilner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consect Due to (or a) co	quence of): Ose for quence of):	il ca		lun	Ĵ	Approximate Interval Between Onset and Death Munth
.8760.	cate be executed physician and the burial-transit	dical Examiner	resulting in death) Last Due to (or as a consequence of): d.							
P.O. Box 6	ath cert attendin for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23d. Date of delivery Month Day Year					
	uires that signed t Id be det	þ	Part II. Other significant conditions con	tributing to death but not res	sulting in the unde	erlying cause give	en in Part I.		_	ute to the cause of death?
ecor	law requir as been si 2 should l	Completed						24a. Was an autopsy		re autopsy findings available or to completion of cause of
<u>a</u> B	sicfan: The lav certificate has rector, page 2							performe	ed 3 dea	ath?]Yes 2□ No
, Sit	Physicfan: rthis certific ral director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1. Inpatient 2	ER/Outpatient	3□ DOA Othe	26. Place of Death 4 ☐ Nursing Home		ca 6 □Other	(Spacific)
Division of Vital Records.	or Attanding Physician: The after death. Director: After this certificate his in by the funeral director, page	Certification: 7	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At h building, etc. (Special	28b. Time of Injury ome, farm, street by)	28c. Injury Work M 1 🗀 Y	/at 28 (? /es 2 □ No	d. Describe how	injury occurred	
pl	Hospita 24 hours Funeral tely filled	Medical Co	29a. Certifier 1 Certifying Physical Check only one) 1 Medicel Examination	sician: To the best of my knoter: On the basis of examination and manner stated.	owledge, death or ation and/or inves	ocurred at the tim stigation, in my op	e, date and place, an inion, death occurred	d due to the cau at the time, date	se(s) and mann and place, and	er as stated. d due to the cause(s)
	To the within 2 To the comple	M	29b. Signature and title of certifier Mehta	MD		29c. License	34 47	290 4 AE	Date signed (Month, Day, Year)
_	5		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type, Pri	h char	les stre	et, Bo	Utime-	7 2004 m MD21230
	Sta Registr		31. Date filed (Month, Day, Year)	37 Registrar's Signa	ature Assa	K)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Patrick R. Tonic State of Maryland / Department of Health and Mental Hygiene State Unperd Item#23a-d,2/,PPR ME,331,5/20/1993 Certificate of Death Reg. No. 04 - 2671AKG 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** PATRICK R. TONIC 17 April 2004 10:30 P /Medical 4c. County of Death 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** North Arundel Hospital
5. Social Security Number UNI 6. Sex Glen Burnie
If Under 1 Year | If Under 24 Hrs. | Anne Arundel 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral 1**⊠**M 2□F Days Hours Min. Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director ANNE ARUNDEL MD GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? CIRCLE # 238 USA 2/06/ death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 ò Specify: BLACK 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SCHOOL STUDENT 10TH GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental I Pages 1 and 2 should be SUSAN CHARLES TONIC CARRILLO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CIF. nt of Health a CARILLO -TONIC 493 GIEN MAR GLEN BURNIE, MO 21061 SUSAN other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō 1 Surial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 04.24.04 KING MEMORIAL RANDALISTOWN, MO 1 4 ☐ Donation 5 ☐ Other (Specify) VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTU. NATU PIKE, BALTU. MO 21229 21. Signature of Fuperal Service Licence ang 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac Arrhythmia Physician /Medical Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate the first underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi Hypertensive Cardiovascular Disease resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Renal Thrombotic Microangiopathy use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, ate has been signed page 2 should be 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No Hospital or Attending Physicien: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Yes 2 No 1 Inpatient 2X ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1X Natural 1 Yes 2 No 24 hours after death. Funerel Director: A investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainly as success.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 2 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 19, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AV 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 2 1 2004

			For State Registrar		State	of Maryla	and / Dep <i>Ce</i>	artmer <i>rtificat</i>				lental H	ygiene Rog. No	/ (004	1210) 9
	Physicia		1. Decedent's Name	(First, Middle	, Last)							2. Date of I	Da		Year	3. Time of Death	
	/Medic		Beatrice									April		2004		1640 PM	<u></u>
	Examin	er	4a. Facility Name (If I		-					Location	of Death		40	. County			
7,546		2.	Upper Che 5. Social Security Nur		Ke Mealc		cer rs. last birthday,		Bel <i>P</i>	If Under	24 Hrs.	8. Date of E	Birth		ford 9. Birtho	ace (State or Forei	an
The Section 1	Funeral Director		172-05-0		1 ☐ M 2 💢 F		35 Yrs.	Months	Days	Hours	Min.	(Month, L	Day, Year	918	Penn	lace (State or Forei try) sylvania	
13	1.42		Usual Residence of D	Decedent								J G G I	/ -				_
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death with the Maryland	23a or 2	al Dire	10e. Street and Num! 517 W. R.		ctory Ro	ad		10f. Zip	2	21015				U	Vhat Coun		
1640 21215-0036 od within 72 hours after dea		by Funeral	11. Marital Status 1 Never Marrie 3 Widowed 4		Armed 1 ☐ Ye	ecedent Ever in Forces? s 2 ½ No Give Dates:	n U.S. 13.	Was Dece II Yes, spe 1 Tes		ispanic Ori in, Mexicar Specify:		ecify Yes or f Rican, etc.)	No-		e - Americ k, White, Wh:		
25-0	natur Jical	eted		15. Decedent	's Education	d)	16a. Dece (Give	dent's Usu kind of wo	al Occup	ation during mos	t of work	ing	16b. K	Cind of Bu	siness/Ind	dustry	
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Q 5	Hygiene. other than	CO	17. Father's Name (F	First Middle	l act)		HOILE	allakei		18 Moths	ar's Name	e (First, Midd					
rlan	la b	To Be	Cyrus Macl	nan Ec	kman					Rack	nael	(u/	/k)	Spr	ecker		
	5 ~ =		Joseph J.				517	West	Ring		tory	Road,	-				
4から164 Baltimore, Mary	Department of Healt Important: If item 2 any injury or other once.		20a. Method of Dispo 1 🖾 Burial 2 € 1 Donation 5	Cremation	3 □Removal fro	m State	b. Place of Disp cemetery, cre aint Sta	matory`or	other plac			-04		ocation - ndalk	City or To	wn, State	
Baltin	Departm Importar any injur		21. Signature di Fin									ne, P.A			-		
			23a. Part1. Enter the sheek, or heart	e disease, or failure. List	complications that	it caused the de		ter the mod	de ol dyin	g, such as	cardiac		arrest,			Approximate Interval Between Onset and Death	
	hysician Medical		Immediate Cause (F disease or condition resulting in death)	Final	a. Due	oma to (or as a cons	- due	to	9r	1 tra	cer	ehra	160	cedi			
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Becords, P.O. Box 68760, The law requires that the death certificate be executed.	the attending thed for use as	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2 9	nonths?	1 Liv	outcome of pre- e birth 2 ☐ F egnant at time o known	etal death 3	⊒Ectopic p ⊒ Other <i>(si</i>					-	23d. Dati Mor	a of delive	ry Day Year	
IS, P.	signed by	by	Part II. Other signific	cant condition	ons contributing to	death but not	resulting in the t	underlying (ause give	en in Part I			tobacco	M	ibute to th	e cause of death?	wn.
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ien in	is certifical	Be (25. Was case referre	ed to medica							of Deat	n (Check only	one)				
of Vifa	this ce	၉	1 □ Yes 2 💢 N				ER/Outpatie			4 LI NE	-	me 5□Re)	_
Sion o	Afte	ion:	27. Manner of Death 1 Natural	5 Pendin	g (M	te of Injury onth, Day Year	r) 28b. Time of Injury	M :	Worl			28d. Describ	e how inju	iry occurr	ed		
Sici	death. :tor: After	icat		investi 6 🗆 Could	not be 200 Bl	ace of Injury - A	At home, larm, st			Yes 2□	-	28f Location	(Street a	nd Numbi	er or Rura	l Route Number,	_
70 5	after d Direct J in by	Certification:	4 Homicide	determ	bu	ilding, etc. (Spe	ecify)		y, omoc				own, State			,	
Hospital and a spiral and a spi	within 24 hours after death To tha Funeral Director: completely filled in by the:	Medical C	29a. Certifier (Check only one)	1 Certifyir 2 Medical	ng Physician: To Examiner: On the and m	the best of my be basis of exame	knowledge, dea sination and/or ii	th occurred ovestigation	at the tim	ne, date ar pinion, dea	id place, th occurr	and due to the	e cause(s e, date an	and ma d place, a	nner as st and due to	ated, the cause(s)	
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	- > - 0		•	1	South	3)		Ī) 18	42	4		Ap	yil-	16.	2004	
-	7		30. Name and addre	rek	h MD	ause of death (I	Item 23a) (Type	Print)	1 Ro	ad,	Fa	11ston					
180	Sta Registr		31. Date liled (Month	2 1 20	04	. Registrar's Si	ignature	door	61								

		1- For State of Maryland / D	Department of Health and M Certificate of Death		ene 2004 12110
		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
F-1	/siciar	VICTOR LUCTAT VOLOT		April	16 2004 8:25P M
	ledica aminei		4b. City, Town, or Location of Death		4c. County of Death
		Pear Tree Assisted Living	Pasadena		Anne Arundel
Fund	eral	5. Social Security Number 6. Sex 7. Age (In yrs. last birt	Months Days Hours Min.	8. Date of Birth (Month, Day, Y 12/05/1	9. Birthplace (State or Foreign Country)
Direc	tor	210-09-1001 90	frs.	12/05/1	905 Baltimore, MD
pur *	52	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
faryla	200				1 ☐ Yes 2 ☑ No
the N	Director.	10e. Street and Number	10f. Zip Code	100	. Citizen of What Country?
with			21122		U.S.A.
eath ns 23	Timeral	2 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp	ecry Yes or No-	14. Race - American Indian,
fter c		Armed Forces? 1 □ Never Married 2 □ Marned 1 □ Yes 2 ☑ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
03(0)	Exar Pv	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: White
ING 21215-0036 be filed within 72 hours after death with the Maryland ital Hygiene. In other than "natural", or Items 23e or 28e-f show	t, the Medical B	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work	ing 16	b. Kind of Business/Industry
Z igi	Mary Co.	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)		
led w			hinest		elf Employed
De fil		17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma.	,
arylan should be and Mental	e de la		N. III. A. I	Unknow	
7 2 2 4	traumatic		Mailing Address (Street and Number or Run		
- 650	other	20a Method of Disposition 20b. Place of	126 Pollar Ridge Road		IId , IVID ZIIZZ c. Location - City or Town, State
Saltimore, semit. Pages 1 au Dep. rtment of Hea	0 0	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	y, crematory or other place)		etters
Itin it. P. rtme	5	'4 □Donation 5 □Other (Specify) 21. Signature of Funeral-Service licenses	aven Cemetery 4/2	1/2004	Glen Burnie, MD
Baltimo permit. Pages Dependent of Important: If i	S S	District A	22. Name and Address of Facility St. 3111 Mountain Road	allings F	uneral Home, P.A.
		23a. Part1. Enter the disease, or complications and used the death. Do n			Approximate
Dhusis		shock, or heart failure. List only one cause on each line.	ARTERY	TICE	A P Interval Between Owser and Ocarts
Physic /Medi	_	disease or condition resulting in death)		20121	1101- 10/1110
Exami	ner	FCCENI	TIAL HYPER	JEN	SIDN 32YEARS
	i i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	n():		TVIII-
oetna J	ral-transit	Cause (Disease or kiluy) that initiated events c			
O, e exe	Tal-		rf):		
cate be executed physicien and	the bu	d			
C 65 Brtific ling p	Mag	IF FEMALE:			
death certific	or us	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy		23d. Date of delivery Month Day Year
. 0 0	letached for use as	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		
i i	detac Dh	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I	23e. Did tobac	co use contribute to the cause of death?
dS, F	D A	COUT	and an activity and activity and activity		2 No 3 Probably 4 □Unknown
v requ	should	CHRONIC PENIAL FAI	IURE		
The lav	page 2 should	CHRONIC RUNNE (1)	LVIL	24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
	or. pa			1 Yes 2 €	
Sicia sicia	director.	examiner?	Othor	me 5 Residenc	ASSESSED IVING
Of Phys	= -	- I I I I I I I I I I I I I I I I I I I	ime of 28c. Injury at	28d. Describe how	
ISION C Itending F death. stor: After	5	1 Matural 5 Pending (Month, Day Year) In 2 Accident investigation	njury Work? M 1 ☐ Yes 2 ☐ No		
DIVISION I or Attending after death. Director: Afte	e j	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number,
telor safte	ed in by the funera	B Showing, All (Speeding)		Ony or 10mm, 0	naio)
dospi t hour	pletely fill		death occurred at the time, date and place,	and due to the caus	e(s) and manner as stated.
DIVISION Of VITA To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific	mplete				
T ₹ 0	8	29b. Signature and title of certifier	29c. License number	() (D	PH 2 0 2 0 4
1,		20th man Original construction of the Construc	Tuef Clien of A		THETHE
4		30 Mama and address to serion who complified cause didentifilled 23a) (TYPOS PRINTING OF A RUT	LHIE	HIGHWAL
	State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	BALIMORE	MITTEN	MN 1) 41 443
Pa	gistra	APR 2 1 2004	1 10 3		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #5 PER FH G830 Cértificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Joseph Weber, Jr. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltmore If Under 24 Hrs. n/a Hospital 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F Yrs. Director 85 1918 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Modical Examinar must be notified at 1 Yes 2 □ No Directo Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1908 Deering Avenue 21230 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Ø Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itel important: If item 27 is marked other than "natural; or itel any injury or other traumatic event, the Medical Examines once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Letter Carrier 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Weber, Sr. C. Dellman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Weber / Wife 1908 Deering Avenue, Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ➡Burial 2 ☐ Cremation 3 ☐ Removal from State

'4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 4/21/2004 Elkridge, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, o shock, or heart failure. Lis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one gause on each line. Interval Between Onset and Death Immediate Cause (Final RUAtured Physician Illar disease or condition resulting in death) hours /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine Cause (Disease or injury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 an/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Physicia Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an performed? 23 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 ☐ Inpatient → R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending 1 Natural 2 Accident death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Physician Attending 30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print) Avenue Michae 900 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Weber, Joseph E.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Carolyn Winner 1140 AM Lee April Z004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hagerstown
If Under 1 Year | If Under 24 Hrs. Washington County Hospital Washington County 8. Date of Birth 06/04/1941 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🕏 F Months Days Hours Yrs. Director unk Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other then "naturel", or items 23a or 28e-f show or other treumetic event, the Madical Exertiser must be notified at 10b. County MD Washington Hagerstown 1 ☐XYes 2 ☐ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 21740U.S.A. 1101 Salem Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1□Yes ŽŽNo Baltimore, Maryland 21215-0036 Specify: White Specify: Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then 'any injury or other treumetic event, Ite Me 2002. Elementary/Secondary (0-12) College (1-4or 5+) 12th Housewife N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary F. Gattens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry E. Winner (Husband) 1101 Salem Ave. Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 Donation 5 ☐ Other (Specify) Howard Med. School 4/19/2004 Washington, DC 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licensee 3821 14th ST, N.W. WDC 20011 23a. Part1. Differ the effease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Carciaona ase or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Waknown 24b. Were autopsy findings available prior to completion of cause of death? Pulinan 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Hipatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No after death. 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a
To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier test MD D18019 MRIL 19, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAGERITOWN MD 21740 VASAWT DATTO MD 340 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 2 1 2004

		- State Registrar AMEND ITEM #24 1. Decedent's Name (First, Middle, Last)		2015 BOD 1	ibicale of	Dealii	2. Date of Deat		3. Time of Death
sicia edic		Anna Marie Bascu	e					16, 2004	8:30 P M
mine		4a. Fecility Neme (If not institution, give				r Location of Death		4c. County of Deer	
		Calvert County N			If Under 1 Year	rederick	C Data of Dieth	Calvert	
ral tor		010 10 1100	7. Age (In yrs. last b	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Feb. 12	Year) 1912 Was	thplace (State or Foreign buntry) hington, DC
	}	Usuel Residence of Decedent 10a. State 10b. County	10c. City, Tov	wn or Loc	ation		· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits
2	0	MD Calvert C	ounty Dunk	kirk					1 ☐ Yes 2 No
other traumatic event, the water a fact that we will see	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	ountry?
	E C	3519 King Drive			20754			U.S.A.	
	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. W	Vas Decedent of H Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
	F	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give	1	☐Yes 25 No	Specify:		Specify: W	hite
	d by	3 ₩idowed 4 □ Divorced	Year or Dates:		ent's Usual Occur	nation		16b. Kind of Business	
3	Completed	(Specify only highest grad	e completed)	(Give I	kind of work done OO NOT use retire	during most of world)	king		,
100	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Tomen	naker			Home	
ent,	d)	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, i	Maiden Sumame)	
10	To B	Joseph Regan				Christ	ine Mari	e Brown	
E I		19a. Informant's Name/Relationship (7)						r, City or Town, State, .	
10 Je		Barbara B. Joseph			1			aryland 20	
no re		20a. Method of Disposition 1	cemet	of Dispos	sition (Name of natory or other pla	(B) Marc	h 20, 📗	20c. Location - City or	
5		*4 ☐ Donation 5 ☐ Other (Specify)	Fort I		oln_Ceme			Brentwood,	
eny injury or or		21. Signature of Funeral Service Licens	800					1 Home Cal	
o a		Michael W. Le	e i	812	25 South	ern Maryl	and Bivo	l., Owings,	Approximate
*		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	4	o not ente	er the mode of dyn	ng, such as cardiac	or respiratory arr	631,	Interval Between Onset and Death
an		Immediate Cause (Final disease or condition resulting in death)	a ANOREXIA						
ai er		Tooling in docum	Due to (or as a consequence	e of):					
	P.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence	e of):	-				
	Examiner	Cause (Disease or injury							
	Exa	that initiated events resulting in death) Last	Due to (or as a consequenc	e of):					
	cai		d						
	Completed by Physician/Medi	IF FEMALE:	1/11						
מפומכו וחופס פס ווופן	an/	23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea		Ectopic pregnanc	у		23d. Date of de Month	livery Day Year
ŝ	Sici	in the past 12 months? 1 ☐ Yes 2 ĀNo 9 ☐ Unknown	4 Pregnant at time of death 9 Unknown	5 🗆	Other (specify) _				
	Phy	Part II. Other significant conditions co	antributing to death but not resulting	r in the ur	nderlying cause or	ven in Part I	23e. Did to	bacco use contribute t	o the cause of death?
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	etec						24a. Was a	24h Were a	utopsy findings available
7 eC	ם	HYPOTHYRO					autop. perfor	sy prior to med? death?	completion of cause of
irector, page 2 s		DEMENTIA	•			OR Plant of Day	1 ☐ Yes ath (Check only of	341	s 2 No
recto	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/6	Outpation	at 3 DOA Ot			ence 6 Other (Spe	acity)
in i	. To	27. Manner of Death		. Time of	28c. Inju	iry at		ow injury occurred	sony
5	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		ork?]Yes 2⊡No			
E Uy er	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, str	eet, factory, office		28f. Location (S City or Tow	Street and Number or F m. State)	lural Route Number,
comptetely tilled in		(Check only 2 Medical Exam	ysician: To the best of my knowled liner: On the basis of examination	ige, death and/or in	h occurred at the t vestigation, in my	ime, date and place opinion, death occu	a, and due to the curred at the time, c	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
iet	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Date signed (Mon	ith, Day, Year)
Ë		230. Signature and title of certain	7 ma-			2370			
completely tilled		1/1/1/	10 111		0/0	210		March 17,	ZUU4
сошь		7,000	ampleted as of dr (14	a) /T	Drint)				
сошо		30. Name and address of person who of Peter L. Wisniews				Blad De	mkirk N	Maryland 90)754

			. 101	epartment of Health and I Certificate of Death	Mental Hygier	2001 10111
	Physici	an	1. Decedent's Name (First, Middle, Last) Shirley Lenore Benton		2. Date of Death Month	Day Year 6:10 A M
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street and number) 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	4b. City, Town, or Location of Death (c) (d) (d) (d) (d) (d) (d) (d) (d) (d) (d	8. Date of Birth (Month, Day, Yea	4c. C unity of Death Allegany 9. Birtholace Istate or Foreign
	Aaryland f show ed at	or	Usual Residence of Decedent			10d. Inside City Limits 1 ☐ Yes 2 No
	s or 28a-	Funeral Director	10e. Street and Number RR 5 Box 36	10f. Zip Code 26726	_	Citizen of What Country? U.S.A.
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Itema 23a or 28a-f show or other traumatic avant, the Medical Examiner must be notified at	þ	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Decify Yes or No- Decify Yes or No-	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	d within 72 ho giene. ir than "natur it e Modical I	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king 16b.	Kind of Business/Industry Own home
pur	be filed htal Hyg ed othe avant,	Be	17. Father's Name (First, Middle, Last) Raymond Ingersol	18. Mother's Nam	e (First, Middle, Maid	en Sumame) rence L. Smith
Maryland	12 should h and Mei 7 Is marke traumatic	ပ္	_	Mailing Address (Street and Number or Ru	ral Route Number, City	y or Town, State, Zip Code)
nore, l	ages 1 and nt of Healt If itam 2: or other		20a. Method of Disposition 20b. Place of cemeter, 1 △Surial 2 □ Cremation 3 □ Removal from State	Disposition (Name of r, crematory or other place)	Date 20c.	Location - City or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 is marked other than 'a may injury or other traumatic avant, Ita M. ODGe.		14 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Phomas Cemetery 4 22. Name and Address of Facility Markwood Funera P.O. Box 912, K	1 Home. 1	Inc.
8760,	Cate be executed //Medical Examiner and street burial-transit street burial-transit	dicai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last Due to (or as a consequence of the condition of the cond	n):		Approximate Interval Between Onset and Death
P.O. Box 68	The law requires that the death certifica te has been signed by the attending pl page 2 should be detached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
	quires that n signed by	by	Part II. Other significant conditions contributing to death but not resulting in	accident.	,	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Il Records,		Completed	chronic obstructive	d'sec sel	24a. Was an autopsy performed?	
on of Vital	> .00	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1	patient 3 DOA Other: 4 Nursing H	th (Check only one) ome 5 Residence 28d. Describe how in	6
Division		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Street and City or Town, Sta	and Number or Rural Route Number, ite)
	To the Hospital or within 24 hours after Fo tha Funaral Dir completely filled in	edical C	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, and manner stated.		and due to the cause red at the time, date a	(s) and manner as stated. Indiplace, and due to the cause(s)
	To th within To th		29b. Signature and title of certifier Pulmonary Cart	7.6 29c. License number 1005385	5 29d. E	PA: 14, 200 4
•	8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sacred Hea	Prive	001
	Sta Regist	ate rar	30. Name and address of person who completed cause of death (Item 23a) (Stanle Joseph Mctas: K 31. Date filed (Month, Dak, Year) APR 2 1 2004	Combertan ?	LIMO	21502

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10,2004 ANNABELLE APRIL N/M/NCASTONGUAY 8:45A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WALDORF HEALTHCARE WALDORF CHARLES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 💢 F Yrs. Director 4,1928 OHIO MAY 187-24-1835 Usual Residence of Decedent r 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No CHARLES WALDORF Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with I ment of Health and Mental Hygiene.
ant: If itsm 27 ie marked other then "natural", or Iteme 23a or: ury or other treumatic event, the Modical Examinat must be I 4140 OLD WASHINGTON RD. 20602 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐ Yes 2 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo by Specify Specify: WHITE 3√□ Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) REST. 8 WAITRESS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EMMERSON DUNHAM RUTH WILSON ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NEWBURG, MARYLAND 2066# BETTY LOU THOMPSON-FRIEND 13300 PICCOWAXEN RD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 4-11-04 ALEXANDRIA, VIRGINIA MO0479 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 21. Signature of Funeral Service Licensee rel 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. So not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) ONGEST VC **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Oue to (or as a consequence of) Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ TUC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been signature Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate ha 2 □ No 1 Yes 2 1 No 1 Tyes or Attending Physician: After this certification 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 KNo Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Alatural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation М 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours at To the Funeral D completely filled in Hospital Medical 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D44436 HENDIM 30. Name and addre is of person who completed cause of death (Item 23a) / ype, Print) 102 PALL MEllON CT WALPORE MD 20602 ASHVINKUMAR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State doeun St Registrar

Amend Items 10a, b, c, e, f; 19a, b per Inf., G830, 04/21/04dhb

1- For Amend Item #19b per Informant C330 per Information C410 per Info 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Vear **Physician** PM 3 **JOSEPH** 3 2004 CAMPBELL, JR. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Worcester Ocean City 107 Atlantic Ave. Unit 104 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 **X** M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 196-36-9647 55 11/20/1948 PA Director Usual Residence of Decedent 10b. County Gloucester the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State show item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Exercises must be redified at PA NJ 1X Yes 2 □ No Williamstown Director **Philadelphia** Philadelphia -10e. Street and Number 50 Emory Pl. 10g. Citizen of What Country? 08094-9742 1514 S 28th St 19146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Fireman Merchant Marines q 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Campbell, Sr. Jean Bobb 19a. Informant's Name/Relationship (Type, Print)
Thomas P. Staunton Jr.
Thomas P. Staunton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is rr any injury or other traum once. 28th St., Philadelphia, PA 28th St., Philadelphia, PA Thomas tauntob 20b. Place of Disposition (Name of cemetery, crematory or other place) Inc. 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State

4 Dogation 5 Other (Specify) Philadelphia Crematories 4/2/04 Philadelphia, PA 22. Name and Address of Fine Burbage Funeral Home re of Funeral Service L ass nd uson 110008 108 William St. Berlin, MD 21811 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, but one cause on each line. Part1. Enter the diseas shock of heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE MYOCARDIAL disease or condition resulting in death) INFARCTION MMEDIATE /Medical Due to (or as a consequence of): Examiner SSENTIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HYDERTE NSION Due to (or as a consequence of): Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 X Yes 2 ☐ No filled in by the funeral director, Be 26. Place of Death (Check only one) Motel Other: 4 Nursing Home 5 Residence 6 ther (Specify) Hospital: ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this Room 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After t 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No М death. 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To tha Funaral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 06241 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 203 SNOW ST. SNOW HILL, MD. 21863 DOROTHY ZWORTH 31. Date filed (Month, Day, Year) 32. Registrar's 8ignature State MAR 3 0 2004 Registrar

State

31. Date filed (Month, Day, Year)

29b. Signature and wille

0

32. Registrar's signature

200

30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

29c. License number

OCME

29d. Date signed (Month, Day, Year) APRIL 9,2004

Registrar

			For State Registrar	State of M	aryland / I	Departme <i>Certifica</i>			d Me		jiene •g. No. 2	004	12119
	Physici	an	1. Decedent's Name (First, Middle, Las	n) Camp	Graha	m				Date of Dea Month EBRUAR	Day	Year 2004	3. Time of Death 11:45 a ^M
>	/Medio		4a. Facility Name (If not institution, give	-	Grana		, Town, o	r Location of D		LDROAK		nty of Death	11.45 a
	LXaiiiii	CI	St. Mary's Hospi	tal		Le	onar	dtown			st.	Mary'	's
	Funeral Director		5. Social Security Number 6. S. 547–03–2148		e (In yrs. last bi 94	Yrs. If Und Months	er 1 Year Days		vin.	Date of Birth (Month, Day une 28	, Year)	Cou	
	and w	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	vn or Location							10d. Inside City Limits
	Maryl f sho	ğ	MD Montgom	erv			Si	lver Sp	orino	7			1 ☐ Yes 2 🙀 No
	r 28a	Director	10e. Street and Number			10f. Z	ip Code				0g. Citizen o	of What Cou	ntry?
	23a c	aiD	619 Hyde Road					902				USA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 is marked other than "natural", or items 23e or 28e-f show other treumatic event, the Medical Exemiter marken multiple at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 ☐ If Yes, Give Year or Dates:		1 Nos	edent of Hecify Cub 2 📉 No	lispanic Origin' an, Mexican, P Specify:	? (Specif uerto Ric	fy Yes or No- can, etc.)	14. H B	lace - Ameri lack, White, cify: Wh	
21215-0036	2 hour		15. Decedent's Ed	lucation		. Decedent's Us			addaa		16b. Kind of		
215	within 72 ene. than "n	Completed	(Specify only highest gra	de completed) College (1-4or	5+)	life. DO NOT	use retire	during most of d)	working				
7	e filed within at Hygiene. I other than vent, the Me	Соп		4		dietici	an	10 Mathada	Nama (f	First, Middle,			ealth care
and	d be fill antai H tad ott	o Be	17. Father's Name (First, Middle, Last) Courtney A		Car	am			hryn		Maiden Sun		chofield
Maryland	2 should be and Mental is markad reumatic ev	^T	19a. Informant's Name/Relationship (Type, Print)		b. Mailing Addre	ss (Street	and Number o	r Rural F	Route Number	r, City or Tow	vn, State, Zij	o Code)
	s 1 and 2 of Health a item 27 is other tree		Turner Camp, M.D.	., broth	20b. Place	19 Hyde of Disposition (N	ame of		Spr		1D 209 20c. Locatio	902 n - City or T	own, State
nor	ages int of the t: If ite		1 ☐ Burial 2 🏋 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			ery, crematory`o: politan			2.5 (14	Alexa	ndri a	777
altimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licer		riecto			ss of Facility)-5-(ATEXA	iurra	V A
B	Depared Impo		> When f	3. Hea		Rau	sch	Funera	al H	Home,	P.A.	, Owi	ngs, MD
	Physician /Medical Examiner pnual-Itausit pnual-Itausit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as Due to (or as Ref	a consequence	lee o	1.	ne.					Onset and Death
O. Box 68760,	The law requires that the death certificate be executed at has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d23c. If yes, outcome	of pregnancy			у				Date of deliv	rery Day Year
ds, P.O	ires that t signed by d be detar	by	Part II. Other significant conditions of	contributing to death	but not resulting	in the underlying	g cause gr	ven in Part I.			bacco use co		the cause of death?
of Vital Records,		Completed								24a. Was a autop perfor 10 Yes	an 24 sy med? 2 \Bo	b. Were auto prior to co death? 1 \(\subseteq \text{Yes}	opsy findings available ompletion of cause of
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Ott			Check only or	-		
of	S D	- To	1 ☐ Yes 2 ☑ No 27. Manner of Death	Inpat		outpatient 3		ner: 4 ☐ Nursii		d. Describe h			ify)
on	ling After	tion	Natural 5 Pending 2 Accident Investigation	28a. Date of Inj (Month, D	ay Year)	Injury M	28c. Inju Wo	rk?]Yes 2□No					
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined	280. Place of II	njury - At home, i tc. (Specify)	farm, street, fact	ory, office		28	f. Location (S City or Tow		mber or Rur	al Route Number,
	ne Hospil 124 hour ne Funera letely fills	Medical (29a. Certifier 1 Cartifying Pl (Check only one) 2 Medical Exa-	nysician: To the bes minar: On the basis and manners	of examination a	ge, death occurre and/or investigati	ed at the to	me, date and popinion, death of	olace, and occurred	d due to the d at the time, d	ause(s) and late and plac	manner as s	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	1,118			h .	se number	~	2	29d. Date sig		1
			Va	uno			D61	0888	\$ '		0	3/0	2/04.
	10+1		30. Name and address of person who	completed cause of			MD	20636				•	/
	10+1	oto	RATHI KRISHNAN 31. Date filed (Month, Day, Year)	SHAH ASS	tras Signature	TWOOD	EID.	20030					
	Regis	ate	MAR (8 2004	Clasur.	K A	Selle.	9					

MARY C GRAHAM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 2050 2006 Evelyn R. Garlick U Mori 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1□ M 2√ F 90 October 1,1913 PA 213-24**-**62<u>48</u> Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2√ No Hancock Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21750 USA 220 Creek Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify White 3 Widowed 4 NDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gayle Ira Remsburg Margaret May Lanehart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elisabeth Matulewicz/Grandauchter 4492 Livingston St. Philadelphia, PA 19137 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

22. Name and Address of Facility

permit. Page Department Importent: If any injury o

Examiner

Physician/Medical

Completed

Be

L

Certification:

Medical

Physician

/Medical

10a. State

MD

Director

Funeral

Completed by

Be

Examiner

Funeral

Director

item 27 is marked other then "naturel", or items 23a or 28a-f show other treumetic event, the Medical Examinar must be inclined at

d 2 should be filed within 72 th and Mental Hygiene. 7 Is marked other then "no

Pages 1 and 2 s ment of Health an

the Maryland

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

the attending physician and thed for use as the burial-transit that the death certificate be executed

s ueeq

has

the funeral director,

After

within 24 hours a To the Funerel L

To the Hospital or Attending Physicien:

Division of Vital Records, P.O. Box 68760

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

9 Unknown

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☑ No

27. Manper of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

Immediate Cause (Final disease or condition resulting in death)

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State

4 Donation 5 Other (Specify)

21. Sonatury of Funeral Service Licenses

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. provisc Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):

Mays Chapel

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 4□Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Warfordsburg, PA

141 W.Main St.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one) 28c. Injury at Work? 28b. Time of

1 ☐ Yes 2 ☐ No

04/15/04

Grove Funeral Home, P.A. Hancock, MD 21750-0368

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a Certifier

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

60396

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Murs

31. Date filed (Month, Day, Year)

2 32. Registrar's

200

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Approximate Interval Between Onset and Death

Year

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24a. Was an

autopsy performed

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

20 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year) 29c. License number

04/12/04

1 Yes

B.K.S AHDEESAH C. JANIFER State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** JANIFER COMMIE AHDEESAH APRIL 2004 0327 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5200 BLOCK BICKNELL ROAD MARBURY CHARLES | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | NOV • 13, 1976 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 27 MARYLAND 481-92-8765 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c, City, Town or Location 10a State "netural", or Items 23a or 28e-f ehow 1 ☐ Yes ACNO INDIAN HEAD Directo MARYLAND CHARLES 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20640 U.S.A. 6050 MASON SPRINGS ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. ∏Yes 2X No hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No if Yes, Give Year or Dates: Specify: Specify: BLACK 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7:
Department of Health and Menial Hygiene.
Important: If item 27 is marked other then "ne eny injury or other traumatic event, Ins Medic once. Elementary/Secondary (0-12) College (1-4or 5+) LANDSCAPING CO. LANDSCAPER ASST. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be CYNTHIA DENISE GRAY JAMES FRANCIS JANIFER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6050 MASON SPRINGS RD. INDIAN HEAD, MD. 20640 CYNTHIA D.GRAY-MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) OAK GROVE CEMETERY 4-14-04 NANJEMOY, MARYLAND 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 21. Signature of Funeral Service Licensee M00479 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia... r respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burial-tran Due to (or as a consequence of): eq Physician/Medicai the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ò Month Dav Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1. Yes 2 \sum No 24a. Was an certificate has page 2 autopsy performed? 12 Yes 2□ No Division of Vital director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA AT SCENE Other: 4 Nursing Home 5 Residence 6 Pother (Specify) 1X Yes 2 □ No 2 this funeral 28a. Date of Injury (Month, Day 28b. Time of Injury A 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 Natural 5 Pending Deceased Invere after death. -9-04 investigation 1 ☐ Yes 2 ☑ No left read and stauch thee 2 Accident 3 Suicide 6 Could not be determined 281 Location (Street and Number or Rural Route Number, City or Town, State) \$200 Block of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide road Montary within 24 hours a To the Funaral D BICKNEU RD Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) O.C.M.E 29d. Date signed (Month, Day, Year) APRIL 9, 2004 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

		•	1 - For State Registrar		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Certificate	of Dea	th	Re	g. No.		E Sizo E Em
	Physici	200	1. Decedent's Name (First, Middle, Las						2. Date of Death	Day	Year	3. Time of Death
	Physicia Medic/				Jacob	Keller			A	8 800	14	1855
>	Examin	er	4a. Facility Name (If not institution, give	. 11 . 11	no ta	1 -	own, or Locati				ty of Death	
			5. Social Security Number 6. Se	cialty Ho	SPITA (In yrs. last bir		Year If Un		3. Date of Birth		1timo	ore place (State or Fore
	Funeral Director		200-24-2206 Usual Residence of Decedent	M 2□F			Days Hou	rs Min.	June 15	1931	Pe	enna.
	land ow		10a. State 10b. County		10c. City, Tow	n or Location						10d. Inside City Limi
	Mary -feh	to	Penna. Frankl:	in	Gree	ncast1e						1 XYes 2 1
	or 28e	Director	10e. Street and Number			10f. Zip (10	g. Citizen o		intry?
	th wit		265 North Carlis	le St. Lot	16	1	7225			U.S.A	١.	
	tems	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. Was Decede tf Yes, specif	ent of Hispanic fy Cuban, Mex	Origin? (Spec ican, Puerto R	ify Yes or No- ican, etc.)		ace - Ameri ack, White	ican Indian, , etc.
215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "naturel", or ltems 23a or 28e-f ehow event, the Medical Exartina must be notified at	þ	1 ☐ Never Married 2 🐧 Married 3 ☐ Widowed 4 ☐ Divorced	1 MYes 2 □ No If Yes, Give 19 Year or Dates:	50-53	1 ☐ Yes 2	No Spec	cify:		Spec	ity: Whi	Lte
ק	"natu	ete	15. Decedent's Ed (Specify only highest grad		16a.	Oecedent's Usual (Give kind of work life. DO NOT use	Occupation done during r	nost of working	7	6b. Kind of	Business/Ir	ndustry
717	filed within 72 Hygiene. kher than "nat int, the Medic	Completed	Elementary/Secondary (0-12) 1.2	College (1-4or 5+))	Machin				Mack	Truc	ck
פ	be filed tal Hygid d other event, II	BeC	17. Father's Name (First, Middle, Last)				18. M		First, Middle, M		me)	
ylan	should be and Menta marked umatic ev	10	Elmer Kelle						ret Palm			
Mar	C1 6 7 0		19a. Informant's Name/Relationship (7) Phyllis E. Keller			Mailing Address (
	1 and Health em 27		20a. Method of Disposition	/ WILE	20b. Place of	Disposition (Name	e of	Da Da	-	oc. Location		
٥	Pages nent of I int: If it		1 Burial 2 □ Cremation 3 □ 1 Donation 5 □ Other (Specify		cemeter	ry, crematory`or ott Hill Cer	ner place)	4/14		Freenc		
Baitimore,			21. Signature of Funeral Service Licens		Cedar		_		ineral H			; 1a.
ă	permit. Departr Importa any inji		H. Martin Zu	ruleman	In.	45 S. (nan And Carlisl	e St. (ineral f Greencas	iome 1 stle,	nc. Pa. 1	.7225
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the	ne death. Do	not enter the mode	of dying, such	as cardiac or	respiratory arres	st,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):						
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1	uted 3 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,-						
	exec an an	Еха	resulting in death) Last	Due to (or as a	consequence	of):						
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o n	eath c attend for us	cian	in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti	☐ Fetal death	3 □Ectopic pre 5 □ Other (spe	gnancy				ate of delivi onth	ery Day Year
j	quires that the de n signed by the a uld be detached f	Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		3 G G (10) (3)						
S,	The law requires that the ate has been signed by the page 2 should be detache	y P	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlying car	use given in Pa	art I.	23e. Did toba	cco use cor	ntribute to t	he cause of death?
ğ	w require been sig should b	edi	Dicholes mollitus. Chronic cernal Fihre Respiratory failure	. (ongostiv	e ha	ant Jai	luve.		1 🗆 Yes	2 □ No	3 ☐ Prob	pably 4 Dunknow
ecord	law re as be	ple	Chronic Cemal Fihr	llation .	sleepe	Hon ed			24a. Was an autopsy	24b.	Were auto	ppsy findings availab
r		Completed by	Rospiratory failure	e vent-clep	endor !-				erforme	ed? □ No	death?	
Vital	Physician: Th r this certificate rat director, paç	Be	25. Was case referred to medical examiner?	Hospital:				ace of Death (Check only one)			
0	hys his	.T	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 La Inpatient		tpatient 3 DOA	Other: 4 c. Injury at		d. Describe how			ý)
UIVISION	ding I th. After funer	tlon	1 Naturat 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year)	njury M	Work? 1 ☐ Yes 2		d. 50301150 11011	inquiry occu	1100	
N S	Atter r dea ector by the	ifica	3 Suicide 6 Could not be	28e. Place of Injury building, etc.	- At home, fa	rm, street, factory,	office	28	f. Location (Stre City or Town,	et and Num	ber or Rura	al Route Number,
5	rs after or ral Dir	Certification;										
	To the Hoepitel or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Medical	29a. Certifier 1 L Certifying Phy (Check only 2 Medical Examone)	ysician: To the best of liner: On the basis of e and manner state	xamination an	e, death occurred at dor investigation, in	the time, date n my opinion, o	and place, an death occurred	d due to the cau at the time, date	se(s) and m e and place,	anner as s , and due to	tated. the cause(s)
	To the within To the Comp	ž	29b. Signature and title of certifier			29c.	License numb	er		I. Date sign		Day, Year)
)			- %				D 306	194	4	4/91	04	
	15		30. Name and address of person who o	completed cause of dea	th (Item 23a)	Type, Print)	ori "	outn -i	100/000	L D-	/hw.	e 11/1 2111 -
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	11espire/	04 30	20111 67	S ENTROIS	- 90	min	"1) X X 36
	Registr		APR 2.1	32. Registrar	un 18	Smark	7 :					
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Norma 4:15 pm Marie Lehner April 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nursing Center Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York 6. Sex **Funeral** 1 M 2XXX Feb 01, 081-12-2888 83 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits itam 27 is marked other then "natural", or items 23s or 28s-1 show other traumatic event, the Mudical Experient must be notified at Frederick Maryland Frederick 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 East 16th Street 21701 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Peges 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int If item 27 is marked other then "natural", or ite 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: Specify: White 3 € Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest LaMav L'Hommedieu Alice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emerson Lehner III/Son 22320 CollingtonDrive, Boca Raton, Florida 33428 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ò Department of Important: If eny injury or * 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory Apr 15,2004 Smithsburg, Maryland 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home
106 Fast Church St, Frederick, Maryland 21702 21. Signatur of Funeral Service L Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Chronic Renal Failure 5 years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I Yes 21 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hypertension 1 Yes 2 No 3 Probably 4 Unknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? Coronary Artery Disease autopsy performed? certificate ha 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 🔀 Nursing Home 5 🗀 Residence 6 🗆 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 152 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46015 towell mi April 13, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary P. Howell, M.D., 65-C Thomas Johnson Drive, Frederick, Maryland 21702-4371 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 1 2001 Registrar

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neral	-	5. Social Security Number	6. Sex	7. A	ge (In yrs. last birt	Months		Under 24 Hrs. ours Min.	(Month, Da	rth ay, Year)	9. Birth Cou	nptece (State or For untry)
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2 E		19a. Informant's Name/Relation	onship (Type, F	Print)		. Mailing Address				-		
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of to	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Crematic	on 3∏Remo	wai from State	comoto	Disposition (Namry, crematory or of	ne of ther place)		Date		cation - City or 1	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registre AMEND TIEM #26 PER PHY C831 5/27/04 Gertificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 7:30 P M Moukakos March 18, 2004 (NMN) Panagiotis /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Calvert Memorial Hospital Prince Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours 1X M 2 □ F 82 Yrs. Greece Director 267-87-2882 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County st than "natural", or items 23a or 28a-f show the Modical Examinal must be rigitled at 1 ☐ Yes 2 No St. Leonard Calvert Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 20685 Greece 1955 Matapeake Court Completed by Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Public Transportation Public Transportation Driver other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 12 should be file h and Mental H 7 is marked otf Be (Unknown) Marina Moukakous Michael 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a Important: If item 27 is any injury or other traugonce. 1955 Matapeake Court St. Leonard, MD Marina Johnson (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2004 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Mar 22 Clinton, MD Lee Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signature of Funeral Service Licensee Owings, MD 20736 8125 Southern Maryland Blvd. Gary Gof J. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CALLER MeTastatic /Medical Due to (or as a consequence of): Examiner Jaundice Sequentially list conditions, if any, leading to immediate cause first Underson Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Anemia the attending physician and hed for use as the burial-trar Due to (or as a consequence of): 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No After this certificate has 1 ☐ Yes 2. No Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ⊟Yes 2 🖫 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Medical Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 T Homicide 0 Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D. Shel D 50290 3-19-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) frednich 20678 Prina MD Shah 110, Hosp 31. Date filed (Month, Day, Year) MAR 2 3

State

Registrar

32. Registras Signature

2004

			State of Maryland	d / Depa		Health ar	-	_		10101
			Registrar 1. Decedent's Name (First, Middle, Last)	Cel	tilicate of	Dealii	2. Date of De		704	3. Time of Death
	Physicia		MARY RITA MARLOW				APRII	Day 9,200	Year	8:00P M
8	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location of		4c. County		0.001
		•	CLINTON NURSING & REHAB.CE	NTER		LINTON				EORGES
6,	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. Ia 1		If Under 1 Year Months Days		Min (Month, D	rth ay, Year)	9. Birthpla Countr	ace (State or Foreign
4 E	Director		219-80-1467 X X / /	3 113.			DEC • 1	5,1930	WASH	.,D.C.
	yland		10a. State 10b. County 10c. City	, Town or Lo	cation				100	d. Inside City Limits
	e Mar	ctor	MARYLAND PRINCE GEORGES		CLI	NTON				1 ☐ Yes 2√2 No
	or 26	Directo	10e. Street and Number		10f. Zip Code	705		10g. Citizen of		ry?
	s 23e	erai	9211 STUART LANE 11 Marital Status 12. Was Decedent Ever in U.S.	13 1		735 Hispanic Origin	n? (Specify Yes or N		S • A •	n Indian.
_	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show avent, the Medical Examiner must be notified at	Funeral	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	1			n? (Specify Yes or N Puerto Rican, etc.)	Bia	ck, White, et	tc.
2	ref., o	þ	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 🎇 No	Specify:		Specil	<i>y:</i> W:	HITE
<u>ئ</u>	72 hc natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retir	pation e during most o	of working	16b. Kind of B	usiness/Indu	ustry
ב	within ene. than	duc	Elementary/Secondary (0-12) College (1-4or 5+) 1 2	me.	HOMEMA			OWN	номе	
יי ס	filed Hygi other	Be Co	17. Father's Name (First, Middle, Last)		110112111		s Name (First, Middle			
<u>lan</u>		To B	ALBERT V.POHL, SR.			MZ	ARGARET	AGNES T	COBIN	
Maryland 21215-0036	d 2 should Ith and Meni	·	19a. Informant's Name/Relationship (Type, Print)				or Rural Route Numb	-		
	5 m N L		ALBERT V.POHL, JRBROTHER 20a. Method of Disposition 20b. PI		SPANIS	H MUSS	Date Date	20c. Location		
2	9 = 5		1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State		natory or other pl		-15-04	LAUREI		
Baltimore,	2 E E F .		21. Signature of Euneral Service Licensee MOO479	/7 22	2. Name and Add	ress of Facility				IDAND
ä	Depa Impo any ir		Michael O. Zum	\times I	A PLAT	A.MARY	RAL SERVI	546	<i>i</i> • <i>t</i>	
			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not ent	er the mode of dy	ing, such as ca	ardiac or respiratory a	arrest,	1	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)					A OF		
П	/Medical Examiner		Due to (or as a consequ	ience of):	URINA	RY BLA	DDER			
Ę		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ence of):	-					
K .	scuted ind transit	Examiner	Cause (Disease or injury that initiated events c							
9	tte be executed sysician and he burial-transit	cal Ex	resulting in death) Last Due to (or as a consequ	ience ot):						
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COL	w requ	lete	ALZHEIMERS DISEASE				24a. Wa		Were autop	sy findings available
æ	The la te has	Completed	HTN				auto perf 1 ☐ Yes	ormed?/	prior to comp death? 1 Yes 2	pletion of cause of 2□ No
ta	ian: ntifica ctor, p	BeC	25. Was case referred to medical examiner?			26. Place o	of Death (Check only			
×	hysic his ce	To I	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ I		IL 3 DOA		ing Home 5 🗆 Res			
פחכ	ling P. After 1 funera	ion:	27. Manner of Death 28a. Date of Injury (Month, Day Year)	28b. Time o Injury	W	uryat 'ork? ⊒Yes 2.⊟Ne		how injury occur	red	
isi	death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury, - At no	me, farm, st			28f. Location	Street and Num	ber or Rural	Route Number,
ă	E Sign	Certification:	4 Homicide determined building, etc. (Specify	")			City or To	wn, State)		
	To the Hospital or Atlanding Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be		29a. Certifier (Check only 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinat	wledge, deat	h occurred at the	time, date and	place, and due to the	cause(s) and m	anner as star	ted. the cause(s)
	To the h within 24 To the P complete	Medical	one) and manner stated. 29b. Signature and title of certifier			nse number		29d. Date signe		
	To To	Ī	▶ Rrunnt)		D	5152	0	4-13		*
	1		30. Name and address of person who completed cause of death (Item							
_	4				RN AVE	S.E.	SUITE 31	0 WASH	.,D.C	20032
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrary Signal		A					
DI	MH 17 Ray 1/2		APR 2 1 2004 Descu	20	More					

DHMH 17 Rev 1/2001

ORIGINAL

	1	For State Registrar	State	of Mary	•	artment of H		l Mental Hyç F	giene Reg. No.	2001	+ 12126
Physicia	1	. Decedent's Name (First, Middle, L	ast) Belle M	lannin	~			2. Date of Dea Month April	th Day	Year 2004	3. Time of Death
/Medica Examine		a. Facility Name (If not institution, g			9	4b. City, Town, or	Location of De			County of Deat	
Examine		215 Maloney Roa	.d			Elkton				ecil	
Funeral Director		214-20-8693	Sex 1□M 2⊠F	7. Age (In 82	yrs. last birthday) Yrs.	Months Days	Hours M		, Year)	Co	hplace (State or Foreign untry) ryland
and and	-	Usual Residence of Decedent 10a. State 10b. County		100	c. City, Town or Le	ocation					10d. Inside City Limits
Mary -f sho	ē N	Maryland Cecil			Elkton						1 ☐ Yes 2 💢 No
or 28s		10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Co	untry?
s 23s		215 Maloney Roa	12. Was Dec	andost Ever	in 11 S 12	21921	ienanie Origin?	(Specify Ves or No-		ited St	
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic event, the Molical Exporter must be notified at	Dy runeral	 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced 	Armed F	orces? 2 ⊠ No live	III 0.3.	If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	Specify:	(Specify Yes or No- erto Rican, etc.)		Black, White Specify:	
Maryland 21215-0036 nd 2 should be filed within 72 hours at lith and Mental Hygiene. 27 is marked other than "natural", or r traumatic event, tra Molical Exten	Completed	15. Decedent's (Specify only highest g	Education		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of v	working	16b. Kin	d of Business/	
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Aarylanc 2 should be f 3 and Mental I 18 marked of raumatic evs	2	Ernest Moore					Anne		2:	T- 00-1-	
Mar 12 sh h and 7 Is m traum	1	19a. Informant's Name/Relationship Kathy L. Coffi		i 170				Rural Route Numbe			
Healt Healt tem 2	1	20a. Method of Disposition	II/ Kelat	20	Ob. Place of Disp	osition (Name of	1	Date		ation - City or	
Pages Bent of Int: If i		1 🕅 Burial 2 □ Cremation 3 `4 □ Donation 5 □ Other (Spec		n State (Gilpin M Memorial	matory or other place anor Park	200	il 13,	Elk	ton. M	aryland
Baltimore, Mc permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trea	1	21. Signature of Funeral Service Lic	ensee	ha	Ĥ	2 Name and Addre ICKS HOME	ss of Facility FOR FU	nerals, F	.A.		land 21921
Pnysician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	mplications that ly one cause on a.	caused the each line.	death. Do not en		ng, such as card			LP.	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death) Sequentially list conditions,	b		nsequence of):			•			
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rtificate	Medical	IF FEMALE:	d							10	
P.O. BOX 66 that the death certific ed by the attending p detached for use as	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		birth 2 🗍	Fetal death 3	□Ectopic pregnancy □ Other (specify)	/		2:	3d. Date of del Month	ivery Day Year
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f Vital Reoysician: The latis certificate has director, page 2		25. Was case referred to medical examiner?					26. Place of D	Death (Check only o			-7
Division of Vital Records, to Attanding Physician: The law requires the death. Director: After this certificate has been signed in by the funeral director, page 2 should be.	0	1 ☐ Yes 2 No 27. Manner of Death 1 Natural 5 ☐ Pending	28a. Dat (Mo	Inpatient e of Injury onth, Day Ye	2 ER/Outpatie 28b. Time of Injury	of 28c. Injur	4 🗀 I VUI SII I	28d. Describe h		Other (Spec	cify)
Division of To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Pla	ce of Injury - Iding, etc. (S	At home, farm, si Specify)	treet, factory, office	.00 20	28f. Location (5 City or Tow		Number or Ru	ıral Route Number,
Hospital or 24 hours afte 5 Funeral Dir. 9tely filled in	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medicel Ex	aminer: On the	he best of m basis of exa	amination and/or in	th occurred at the timestigation, in my convertigation, in my convertigation.	me, date and pla opinion, death or	ace, and due to the occurred at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
To the within 2. To the I complet	Me	29b. Signature and title of certifier				29c. Licens	e number			signed (Monti	
		> Justual	Garan	دبل		900	47471		Upi	if 9th	, 2004
6		1 11	o completed ca	use of death	(Item 23a) (Type	Print) W. H	t2 upu	Elhta w	s an	192]	
Star Registra		31. Date filed (Month, Day, Year)	2 1 200	Registrar's	Signature	& Speciel	9				

Please Type or Print in Black Indelible In	k. Ensure All Copies Are Legible
State of Maryland / Department of	Health and Mental Hygiene

## Find provided in the control of t	E. OL	II.	GER JR. 1 - State Registrar	State of	Marylar	-	artmer <i>rtificat</i>			and Mer	ntal Hy	-	2004	. 121
CARROLL HOSPITAL CENTER 5. Dec. 217-98-6497 100 21F 7. Age (h yes but bringing) 17/106/1176 1999 1901 100.			Decedent's Name (First, Middle		Edwar	d Oli	nger	, Jı	·		Month	Day	, 2004	3. Time of Deal
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Deanna Bennett / sister	d othe	Be	Charles E. C	linger, Sr	•				Dor	is Eyl	er		,	
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23. Part I. First the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, filtering and causes (First the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximation of the complete of the cause of th	nent of He ant: If Itan ury or oth		1 XBurial 2 ☐ Cremation		1210	cemetery, crei k Hill	ch.	other place of G	od A	pril 1	1	Le G	ore, Ma	
Sequentially list conditions, and the standard program of the standard death of the standard program	Departr Imports any inji		21. Signature of Funeral Service	License	_	1.	2. Name ar 36 Ea	nd Addres st Ba	s of Facility	Skile	s Fu	neral Ta	Home neytown	, MD 217
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ves 2 No 9 Unknown 1 Cheek only one 1 Ves 2 No 9 Unknown 1 Ves 2 No 9 Unknown 1 Ves 2 No 9 Unknown 2 Ves 2 No 9 Unknown 2 Ves 2 No 3 Probably 4 Ves 4 Ves 2 No 3 Probably 4 Ves Ves 4 Ves 4 Ves 4 Ves	ysician and he burial-transit		Sequentially list conditions, any control in medial cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (c	oras a conseq oras a cons _e q	uence of):								
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The state of the s	b ed	و ک	Part II. Other significant conditi	ons contributing to dea	ath but not res	ulting in the u	nderlying o	ause give	n in Part I.				,	
27. Manner of Death 1	ate has	Complet									auto	psy ormed?	prior to co death?	ompletion of caus
27. Manner of Death 1 Natural 2 Natu	w E	0	examiner?	Hospital:	patient 2 <table-cell></table-cell>	ER/Outpatier	nt 3 DC	Othe	-				Other (Speci	(fy)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	- 6		1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	gation 4/14/6	of Injury - At he	9:27 ome, farm, str	eet, lacton	120		281.	Location (Street and wn, State)	Number or Run Tyron e	al Route Number, Road is
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Funer Funer ely fill	dical	(Check only 2 Medical	Examiner: On the bas	sis of examina	wiedge, deati	occurred	at the tim	e, date and inion, death	place, and	due to the	cause(s) a	ind manner as	stated.
7 A P. 1 . A 11 A 1 .	To th compl	Me	1 Zafrin	168 A	e "									
State 31. Date filed (Month, Day, Yeer) 32. Registrate Signature 32. Registrate Signature			ZABILICLE	74 AL	1	111 Pe		reet	, Bal	timore	e, Ma	rylar	d 21201	

		1 - For State Ragistrar	State of Maryla	•	artment rtificate				Reg. N	20	04	12125
Physic /Med Exami	ical	Decedent's Name (First, Middle, Last) Aa. Facility Name (If not institution, give s			4b. City, 7		ocation of C	Mont Ap1	:i1 2	20 c. County of D	Death	ime of Dbath- C
Funera Director		210 27 200.		s Dr. s. last birthday, Yrs.		gers 1 Year Days	If Under 24	Min. (Mont	of Birth th, Day, Yea 8 19	Washi (r) 9. 86 1		State or Foreign
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or tems 23s or 28e-1 show any injury or other traumatic event, the Medical Event are must be takilibed at more any	erai Director	Usual Residence of Decedent 10a. State 10b. County MD. Washingt 10e. Street and Number 18248 Colonel He 11. Marital Status	on		10f. Zip	740	panic Origin	n? (Specify Yes Puerto Rican, et	U	citizen of Wha	10	side City Limits □Yes 2 No
21215-0036 ad within 72 hours after of giene. er than "natural", or Iten . The Medical Evarul et	sted by Funeral	1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ (Specify only highest grade	Armed Forces? 1 ☐ Yes 2 M No If Yes, Give / Year or Dates:	16a. Dece	1 ☐ Yes 2	No N	Specify:			Specify: Kind of Busin	White, etc. White	
and 2121; be filed within and Hygiene. ed other than "event, the Mex	Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+) H. Petre	life.	No:	ne	18. Mother's	Name (First, M			e	
e, Maryland and 2 should be file fealth and Mental Hy m 27 la marked oth her traumatic event	2	19a. Informant's Name/Relationship (Ty) Roy H. Petre/Fatl	oe, <i>Print)</i> ne r		Co1.	Henry	nd Number o	or Rural Route Nous 125 Date	lumber, City	or Town, Sta	Md. 2	21740
Baltimore, permit. Pages 1 a Department of He Importent: If item any injury or othe		20a. Method of Disposition 1	emoval from State Mea	dowview	Menno Menno metery 2. Name and	her place mite d Address	4/	6/04	Н	agersto	own, Mo	d.
Pnysicia /Medica Examine		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	he cause on each line. $Hypc$	ath. Do not en	iter the mode	Pesp	, such as ca mal — Bo	ory f	ory arrest,	line	Appro- Interv Onsei	days days days
). Box 68760,) s death certificate be executed he attending physician and led for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	3c. If yes, outcome of preg. Ukive birth 2 Fe Pregnant at time of	vole	Ectopic pre	egnancy	hve	k_		23d. Date of Month	delivery Day	day
I Records, P.O. I The law requires that the de- rate has been signed by the a page 2 should be detached?	Completed by Phy	9 Unknown Part II. Other significant conditions con Mental Rec		esulting in the e	underlying ca	ause giver	n in Part I.		1 ☐ Yes Was an autopsy performed?	24b. Were	Probably e autopsy find to completio h?	4 Unknown dings available on of cause of
of Vita Phyaician: this certific al director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 □ Inpatient 2 [28a. Date of Injury (Month, Day Year)	ER/Outpatie		A Other Bc. Injury Work	. 4 ☐ Nursi		Residence	6 ☐ Other (Sury occurred	Specify)	
Division of the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	il Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Special Special Spec	cify)			date and	City	or Town, Sta			Number,
To the Hose within 24 ho To the Func completely fi	Medical		ner: On the basis of examinand manner stated.		nvestigation,		nion, death		time, date a		due to the ca	
S Regis	tate strar	30. Name and address of person who co 303 W. 7/1 31. Date filed (Month, Day, Year)	ampleted cause of death (It. 32. Registrar's Signature (It.)	Blva	Print) Ha	agei	slou	n Ma	12	1740		

			For State Registrar	State of M	arylan		artmen rtificate			nd Me		-	004	1212
	Physici		1. Decedent's Name (First, Middle, Last MARY JOANNE PO								2. Date of Dea Month APRIL			3. Time of Death 1:27 AMM
***	/Medic Examir		4a. Facility Name (If not institution, give)				Location of	3		4c. County		
33.	Funeral Director		220-34-9130	7. A	ge (In yrs. 49	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	4 Hrs. Min.	8. Date of Birtl (Month, Day FEB 2	1,1955		place (State or Foreign ntry) YLAND
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County MARYLAND CARRO	ĻĹ		y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the	Direc	10e. Street and Number 2551 MURKLE ROAD		-		10f. Zip	Code 21158	3			10g. Citizen of		· ·
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Pyglene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-1 show ship injury or other traumatic event, the Medical Examiner must be neithed at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Worced	12. Was Decedent Armed Forces' 1 Yes 2 If Yes, Give Year or Dates:	?			ent of His		n? (Spec Puerto R	ofly Yes or No- lican, etc.)	, 14. Rac	e - Americk, White,	can fndian, etc.
21215-0036	dwithin 72 ho piene. rthan "natur the Medical	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or	5+)	16a. Deced (Give life.	kind of wor DO NOT us	k done d e retired)	uring most o		g	16b. Kind of B		LIVING
Maryland 2	should be filed vind Mental Hygie s marked other i umatic event, II	To Be C	17. Father's Name (First, Middle, Last) JOHN C. POOLE									Maiden Suman ABETH J		VGS
Man	d 2 shoulth and I		19a. Informant's Name/Relationship (7) BRIDGET L. POOLE/				ng Address MURI				Route Number	r, City or Town, MD 2	State, Zip 1158	Code)
Baltimore,	Pages 1 and 3 ment of Health ant: If item 27 ury or other tr.		20a. Method of Disposition 1 XX urial 2 □ Cremation 3 □ 1 1 4 □ Donation 5 □ Other (Specify,			Place of Dispo emetery, crem KEVIEW	natory or o	ther place		4/17		20c. Location	-	own, State MARYLAND
Balt	permit. Depart import any inj		21. Signature of Funeral Service Licens	Kahere	Hu	1940 M	Z. Name and ZERS-I	d Address	S of Facility RAW F	UNER	AL HOM	E, P.A. STER, M	ם	21157
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of firmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, loading to immediate	a. Due to (or as	a conseq	n. Do not ent	er the mode	of dying), such as ca	ardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
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rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions co	intributing to death I	out not res	ulting in the ur	nderlying ca	iuse give	n in Part I.			_	2	he cause of death?
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Division of Vital	ding Phy a. After this funeral d	atlon; To Be	25. Was case referred to medical examiner? 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpati 28a. Date of fnji (Month, Da		ER/Outpatien 28b. Time of Injury		A Other	r: 4 🗆 Nurs	ing Hom		e) ence 6 ⊟Oth ow injury occurr		v)
Divis	tal or Attend s after death al Director: A ed in by the f	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At ho tc. <i>(Specif</i>)	ome, farm, str	eet, factory	office		28	of Location (St City or Town		er or Pura	Il Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical (29a. Certifier (Check only one)	rsician: To the best iner: On the basis of and manner st	of examina	wledge, death tion and/or inv	occurred a vestigation,	at the time in my opi	e, date and pinion, death	place, an	d due to the ca	ause(s) and ma ate and place,	nner as st and due to	ated. the cause(s)
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	2		30. Name and address of person who c	ompleted cause of		123a) (Type,	Print)		hoster		3110	-		+
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	,		For Sta		partment of Health and		•	
			1 - State Registrar	Ce	ertificate of Death		eg. No.2004	12130
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Deat Month	Day Year	3. Time of Death
	/Media	cal		red Phillips	dh Ch. Taur arl annin at Day	April	12 2004	0710 A ^M
	Examir	ner	4a. Facility Name (If not institution, give street		4b. City, Town, or Location of Dea	th	4c. County of Death	
	Funeral		811 Mechanics Valle 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	North East If Under 1 Year If Under 24 Hrs		Cecil 9. Birtho	place (State or Foreign
	Director		212-22-5034	2⊠ F 78 Yrs.	Months Days Hours Min	June 14,		rty) Cyland
	p. ,		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I				
	ehov	5						0d. Inside City Limits 1 ☐ Yes 2 💆 No
	the N 28e-f	Director	Maryland Cecil	North E	10f. Zip Code	1	0g. Citizen of What Cou	
	3e or		96 Marysville Road		21901	,		
	death ms 2	Funeral	11 Marital Status 12. W	as Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	United St	an Indian,
ထ္	or Ite		1 Never Married 2 Married 1	med Forces? □Yes 2 ②No Yes, Give	1 ☐ Yes 2 ☒ No Specify:	to Hican, etc.)	Black, White,	etc.
Maryland 21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. Id other then "netural", or liems 23e or 28e-f ehow event, the Medical Examinar must be routiled at	d by	3 Widowed 4 Divorced Ye	ear or Dates:				nite
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12	e filed within II Hygiene. other then "	dwo	Elementary/Secondary (0-12) Co	ollege (1-4or 5+)	omemaker		In Her Own	Home
Þ	illed I Hygid other	BeC	17. Father's Name (First, Middle, Last)			me (First, Middle, M		Home
<u> a</u>	should be id Mental marked c	To B	Edgar R. Pugh		Irena	B. Young		
ar)	2 shi and is m		19a. Informant's Name/Relationship (Type, Pi	rint) 19b. Mai	ling Address (Street and Number or R	ural Route Number,	City or Town, State, Zip	Code)
≥,	and in 27	1	Roger E. Phillips/H		Marysville Road, N			
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove	ai ii oiii otate		il 15,	20c. Location - City or To	wn, State
Ħ.	rtmen rtent: njury		*4 □ Donation 5 □ Other (Specify)	Union Ce	1 200-		Union, Mary	land
Bal	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licensee	· a ¬ if	22, Name and Address of Facility HICKS HOME for Fur	erals, P	.A.	
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	is that caused the death. Do not en	.03 W. Stockton St nter the mode of dying, such as cardia	c or respiratory arre	kton, Maryla	Approximate
	Pnysician		Immediate Cause (Final					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	METASTATIC C Due to (or as a consequence of):	OLUN CANCER			CONTHS
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U	be executed ician and burial-transit	Examiner	that initiated events c	Due to (or as a consequence of):				
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687	fficate p phys		d					
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	ires tha signed I be de	þ	Part II. Other significant conditions contribut	ing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to th s 2 ⊒No 3 □ Prob	
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Rec	The law cate has page 2 s	Completed				24a. Was ar autopsy perform	prior to cor	osy findings available inpletion of cause of
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و	ig Phys ter this neral di	n: T	27. Manner of Death 1 Natural 5 Pending	a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work?	28d. Describe ho	w injury occurred	Nesigence
Sion	ttending F death. tor: After the funera	atlo	2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	of or Attend after death Director: A	Certification:	3 Suicide 6 Could not be determined 286	 Place of Injury - At home, farm, s building, etc. (Specify) 	treet, factory, office	28f. Location (Str City or Town	eet and Number or Rura , State)	Route Number,
	Hospitel		29a. Certifier 1 Certifying Physicien	: To the best of my knowledge, dea	th occurred at the time, date and place	and due to the se	use(s) and margar as at	ated
	To the Hospitel or Al within 24 hours after of To the Funerel Direct completely filled in by	edical	(Check only 2 Medical Examinar: C	In the best of my knowledge, dealer the basis of examination and/or in manner stated.	nvestigation, in my opinion, death occu	irred at the time, da	te and place, and due to	the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Month, I	Day, Year)
	4		1 4 MD		D0047711	1	PRIL 13, 20	400
			30. Name and address of person who complet					
	1			06 North Street	- Suite #3 ELKT	on HAM	LAND 2192	<u> </u>
	Sta Registr	-	31. Date filed (Month, Day, Year) APR 2 1 2004	32 Registrar's Signature				
	negisti	- Cal	7.0 K & T E007	property to pop	ener!			

unpend item#23a,27,PER ME,C831,5/18/04eg Georgia I.Stackler Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-02483 State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 RPD Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Day Year Georgia Irene Stackler April 11. 2004 1053 A M /Medical 4e. Facility Neme (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Union Hospital Elkton Cecil | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | OCT 2, 2003 5. Social Security Number 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 2 💆 F Months Maryland Director 218-67-8355 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other then "natural", or Items 23s or 28s-f show other traumstic event, the Medical Examinar must be notified at 1 XYes 2 No Director Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 113 Cherry Tree Lane 21921 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Not Applicable Not Applicable 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 nent of Health and Mental I ant: If itam 27 is marked of William Tige Stackler Amy Elizabeth Freudig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William T. Stackler/Father 113 Cherry Tree Lane, Elkton, Maryland 21921 permit. Pages 1 and Department of Healt Important: If itam 2: any injury or other 1 once. 20a. Method of Disposition April 14, 20c. Location - City or Town, State R. A. FELLIS & 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State West Chester, * 4 ☐ Donation 5 ☐ Other (Specify) 2004 Co. Inc. Pennsylvania 21. Signature of Fuheral Service License 22 Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 Part I. Enter the disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dilated Cardionyopathy /Medical Due to (or as a consequence of) Examiner **Endocardial Fibroelastosis** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (o. as a consequence of). Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by page 2 should 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 5 4 es 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 XYes 2 ☐ No 1 Inpatient 2 ER/Outpatient **X**DOA 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 T Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) O.C.M.E. April 12, 2004 here MD who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Tasha Z.Gireenbera M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

22. Registrar's Signature

State Registrar

31. Date filed (Month, Day, Year)

nil

Name and address of person

MARYARMS

. KOREU 32. Registraris Signature Esque St

2004

who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

APRIL 10,2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) APRTL 1²3 200²4 **Physician** 17:19 м EDA PAUSEK THAYER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** GARRETT GARRETT CO. MEMORIAL HOSPITAL OAKLAND 9. Birthplace (State or Foreign Country)
THOMAS, WV 8. Date of Birth
(Month Day, Year)
11-19-24 7. Age (In yrs. last birthday) 79 Yrs. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** Days Hours Min 1 ☐ M 2 🗓 F 235-30-2960 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City. Town or Location r than "natural", or Items 23a or 28e-f show the Medical Examinar must be notified at THOMAS TUCKER 1 D Yes 2 □ No WV Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 26292 USA P.O. BOX 57 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. other than "natural", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Item 27 is marked other thi any injury or other traumatic event, Ina. 2002. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) KATARINA OBREZA BLAZ PAUSEK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PO BOX 57, THOMAS WV STUART THAYER, SR./HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ROSE HILL CEMETERY 4-17-04 THOMAS, WV 21. Signature of Funeral Service Licensee HINRELE ANTENERIAL HOME, PO BOX 186, DAVIS WV Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MULTIPLE Physician YELDMA Years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physicien: 26. Place of Death (Check only one) After this certific funeral director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death 28b. Time of Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident hours after death unerel Diractor: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier runa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCHWALM E. 31 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar

	•	For State Registrar		artment of Health and Natificate of Death	Reg. No. 2	004 121
	_	Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Dea
hysicia /Medic		Margaret A	A. Vanders		April II	2004 1810 1
xamin	_	4a. Facility Name (If not institution, give street	and number)	4b. City, Town, or Location of Death	4c. County	y of Death
		Union Hospital		Elkton	Cec	
neral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Fo Country)
ector	-	212-16-5174 Usual Residence of Decedent	82 Yrs.		AUG 13, 1921	Maryland
* =	-	10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City L
a de	ğ	Maryland Cecil	Elkton			1 ☐ Yes 2 [
d other than "natural, or tems 23s or 28s-1 show event, the Medical Examinar must be notified at	Directo	10e. Street and Number	1	10f. Zip Code	10g. Citizen of	What Country?
9 3		21 Norman Allen Str	eet	21921	Unite	ed States
E	Funeral	11. Marital Status 12. Wi		Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto		ce - American Indian,
	2	1 Never Married 2 Married 1 [☐ Yes 2 🔯 No Yes, Give	1 ☐ Yes 2 ☒ No Specify:	Specif	
EM.	dby		ear or Dates:	TE 163 224 NO Opecny.	Зресп	White
dica	Completed	15. Decedent's Education (Specify only highest grade com	pleted) 16a. Dece	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired)	king 16b. Kind of B	Business/Industry
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nt, m		8 17. Father's Name (First, Middle, Last)	Ca	shier/Clerk	ne (First, Middle, Maiden Suman	il Sales
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mark	၉	James Jones 19a. Informant's Name/Relationship (Type, Pr	rint) 19b Mail	ing Address (Street and Number or Ru		State, Zin Code)
9 2		Peg S. Lilly/Daught		orman Allen Street		
item 27 other tra	1	20a. Method of Disposition	20b. Place of Disp	osition (Name of	Date 20c Location	- City or Town, State
= 5		1 Deurial 2 Cremation 3 Remov	ral from State North Ea		11 16,	
ortant: injury c e.	1	* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Cemetery	2004 2. Name and Address of Facility		Cast, Marylar
any ir		20	Į (2. Name and Address of Facility IICKS HOME for Fun 03 W. Stockton St	erals, P.A.	Manufacture N
	+	23a. Part1. Enter the disease, or complication				Approximate
		shock, or heart failure. List only one cau Immediate Cause (Final	use on each line.	,	,	Interval Betwee Onset and Dea
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niner			PNEUMON !	4		2 40
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):	7		
ysician and e burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events				
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ed for u	sicia	1 Yes 2 I No		Other (specify)	MC	onth Day Yea
detached	چ	9 🗆 Unknown				
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ති සී	ted	TOUIS ROWAL P	ALLUKO, UK	WARY MACY	1 ☐ Yes 2 Ø No	3 Probably 4 DORK
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e has been sign age 2 should be	Be (25. Was case referred to medical		26. Place of Dea	th (Check only one)	
has been sign ge 2 should be		1 ☐ Yes 2 ☑ No Hospita	1 ☑ Inpatient 2 ☐ EH/Outpatie		ome 5 Residence 6 Oth	
us certificate has been sign director, page 2 should be	2	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how injury occur	rred
this certificate has been sign at director, page 2 should be		2 ☐ Accident investigation		M 1 ☐ Yes 2 ☐ No	Off Leasting (Charter and Number	toron Brand Brand Market
or: After this certificate has been sign the funeral director, page 2 should be		a □ Suicido 6 □ Could not be	 e. Place of Injury - At home, farm, st building, etc. (Specify) 	treet, factory, office	28f. Location (Street and Numb City or Town, State)	oer or Hural Houte Numbel
tor; Atter this certificate has been sign the funeral director, page 2 should be		3 Suicide 6 Could not be determined 280	building, etc. (Specify)			
tor; Atter this certificate has been sign the funeral director, page 2 should be	Certification:	4 Homicide determined 286		<u> </u>	and done as the second second	
Funeral Director: After this certificate has been signisty filled in by the funeral director, page 2 should be	Certification:	4 Homicide determined 286 29a. Certifier (Check only 2 Medical Examiner: C	n: To the best of my knowledge, dea On the basis of examination and/or in	th occurred at the time, date and place ovestigation, in my opinion, death occu		
Funeral Director: After this certificate has been signisty filled in by the funeral director, page 2 should be	edical Certification;	4 Homicide determined 286 29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: Call	n: To the best of my knowledge, dea		rred at the time, date and place,	and due to the cause(s)
Director: After this certificate has been sign in by the funeral director, page 2 should be	Certification:	4 Homicide determined 281 29a. Certifier (Check only one) 1 Certifying Physician (Check only one) 2 Medical Examiner: Call 29b. Signature and title of certifier	n: To the best of my knowledge, dea On the basis of examination and/or in and manner stated.	29c. License number	rred at the time, date and place, 29d. Date signe	and due to the cause(s) ad (Month, Day, Year)
Funeral Director: After this certificate has been signisty filled in by the funeral director, page 2 should be	edical Certification;	29a. Certifier (Check only one) 29b. Signature and title of certifier Month of the control of the certifier (Check only one) 29b. Medical Examiner: Call of certifier Month M. Ma	n: To the best of my knowledge, dea On the basis of examination and/or in and manner stated.	29c. License number	rred at the time, date and place, 29d. Date signe	and due to the cause(s) ad (Month, Day, Year)
Funeral Director: After this certificate has been signisty filled in by the funeral director, page 2 should be	edical Certification;	4 Homicide determined 281 29a. Certifier (Check only one) 1 Certifying Physician (Check only one) 2 Medical Examiner: Call 29b. Signature and title of certifier	n: To the best of my knowledge, dea On the basis of examination and/or in and manner stated.	29c. License number D0056621	rred at the time, date and place, 29d. Date signe	and due to the cause(s) ad (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State RegistraMEND ITEM #8 PER FH C831 5/06/04 JHCertificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0/50 4 WILLIAMS MARCH 2004 LANA RAE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Regional Medical VICONICI Center Misbury reningua If Under 1 Year | If Under 24 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours 1 ☐ M 2 🕅 F MARYLAND 222-26-2940 60 APRTL 10, 1943 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2X No WORCESTER WHALEYVILLE MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 11602 SHEPPARDS CROSSING ROAD 21872 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned 1 ☐ Yes 2X No WHITE 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) COORDINATOR EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JR. LEE SMITH ALTCE GEORGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12516 NATURE PARK DR., OCEAN CITY, MD 21842 DR. SEAN A. WILLIAMS/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CREMATORY OF DELMARVA! 3/10/04 DELMAR, DELAWARE * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Vousse HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Wer 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) racerebra hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

or itams 23a or 28a-1 ahow

Director

Completed by Funeral

Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Depertment of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f ahow any injury or other traumatic avent, the Moulcal East niner most be rutified at

rsician and burial-transit as

Williams, Lang

Examine Physician/Medical by Completed Certification: Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ◯ No

27. Manner of Death

Naturai

2 Accident

3 Suicide

29a. Certifier

4 Momicide

24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 28 No 1 Yes

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

TSCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

28c. Injury at Work?

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

ame and address of person who comple -- cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) State Registrar

MAR 1 1 2004

32. Registrar's Signature

1 Inpatient

28a. Date of Injury (Month, Day Year)

of or Attending Patter death.

I Director: After

Eller II SI, polisbur

2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

	-	For Stete Registrar	State of Man	yland / De C	partment of F ertificate of	lealth and I Death	Mental Hygie		4 12137
Physici /Medic		Decedent's Name (First, Middle, I IIda	Jane	Walke	er		2. Date of Death	15 200	3. Time of Death
Examin	er	4a Fecility Name (If not institution, g ADV 101 5. Social Security Number 6.	cly Nursir	Mast birthda	OR OWN	or Location of Death		4c. County of De	Birtholace VState or Foreign
Funeral Director	STAR STAR	218-34-4953	1 M 2 K	98 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y Sep 2,	1905	Country) WV
death with the Maryland ms 23a or 28a-f show in ust be notified	tor	10a. State MD 10b. County Was	hington	Oc. City, Town or Bo	Location onsboro				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
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ING Z IZ 13-UU30 be filed within 72 hours after death with the Marylan lal Hygiene. Id other than "natural, or litems 23a or 28a-f show seent, the Modrel Examiner and the notified a	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 You If Yes, Give Year or Dates:	er in U.S. 1	3. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S van, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Black, W	merican Indian, hite, etc. White
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d Z Z Z I Z	Com	17. Father's Name (First, Middle, La		Hon	nemaker	18. Mother's Nan	ne (First, Middle, Ma	Own Hom iden Sumame)	ie
	To Be	Ira S. Malone	7 0.11	10, 14		1	uri A. (Wag		
and 2 alth a alth a		19a. Informant's Name/Relationship Pauline Wetzel	daugh	-		en Lane	ral Route Number, C Hagers		
00		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		20b. Place of Dis cemetery, o Hillcrest	sposition (Name of trematory or other pla Memorial Pai	rk		c. Location - City Cumberl	
Baltimor permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service Lie	ensee Aug f	11	22. Name Scarpe		Home, P.A. ue: Cumberla	and MIX 24	Loo
Physician /Medical		23a Fart1. Pleter the disease, or or shock in heart failure. List or immediat Gause (Final disease or condition resulting in death)	pmplications that caused the draws of the dr	NEMI	enter the mode of dyi	ng, such as cardiad	or respiratory arrest		Approximate Interval Between Onset and Death
ate be executed Aysician and the burial-transit	Ilcai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ONG C Due to (or as a c		HEART	FAICUR	Ē		20%
Records, P.O. Box 687 The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death	3 □Ectopic pregnand 5 □ Other (specify) _	y		23d. Date of Month	delivery Day Year
ds, P. uires that the signed by the detail	by	Part II. Other significant condition	s contributing to death but	not resulting in the	e underlying cause gi	ven in Part I.			to the cause of death? Probably 4 Dunknown
I Records, The law requires t ate has been signe page 2 should be o	Completed						24a. Was an autopsy performe	d? prior death	autopsy findings available to completion of cause of ?
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of Vita Physicien: rthis certific	P	1 ☐ Yes 2 X No 27. Manner of Death	Hospital: 1 Inpatient	2 ER/Outpa 28b. Time	tient 3 DOA	110000	lome 5 Residence 28d. Describe how		pecify)
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To the Hospital within 24 hours a To the Funeral I completely filled	Medical (29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of caminer: On the basis of eand manner state	xamination and/o	eath occurred at the t r investigation, in my	ime, date and place opinion, death occu	, and due to the causured at the time, date	se(s) and manner and place, and c	as stated. due to the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier	146	? ~	1	se number		Date signed (Mo	
2		30. Name and address of person w		th (Item 23a) (Ty	pe, Print)				
St	ate	Khalid Waseer 31. Date filed (Month, Day, Year)	32. Registrar'	s Signature	1126	Opal Cou	urt Hagerst	own MD	Z1/4U

			State of Maryland / Department of Health and Ment 1- State Registrar Amended 3-1-04 item #1/wchd/Sertificate of Death	tal Hygien Reg. N	e2004	12138				
1	Physici	an	1. Decedent's Name (First, Middle, Last) DITTLE LIHATEV		lay Year	3. Time of Death 0225 A M				
	/Medic	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		lc. County of Death					
1	Examin	er	PENINSULA REGIONAL MEDICAL CENTE SALISBURY		Hicomic	20				
-	Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Divided the security Number North Nor	ate of Birth Month, Day, Yea	(r) Cou	place (State or Foreign intry)				
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	ryland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☑ No				
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	sth with the Marylan 23a or 28a-f show	Dir	10e. Street and Number 10f. Zip Code 14975 Woody Road 19956		U.S.A.	,				
	ltams 2%	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify V If Yes, specify Cuban, Mexican, Puerto Rican		14. Race - Ameri Black, White					
30 /	thin 72 hours after death with the Maryland e. an "natural", or Itams 23a or 28a-f show Medical Examiner must be multied at	Completed by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Year or Dates:	,	Specify:	hite				
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99 215	ig , g	piet	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)							
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and	should be filed within nd Mental Hygiene. I marked othar than umatic event, the Men	To Be	William Thurman Windsor Violet Mae							
821 Mary	s 1 and 2 should be filed wit if Health and Mental Hygien item 27 is marked othar th other traumatic event, the	F	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Rou	ute Number, City	or Town, State, Zi	ip Code)				
	and 2 lealth a m 27 is		WOODIOW DI WINGER	cel, DE	19956 Location - City or T	own State				
Jore			1 M Burial 2 Cremation 3 Removal from State	1	Laurel, D					
altimore,			1. Signature of Funeral Service Licensee Odd Fellows Cemetery Feb. 28, 22. Name and Address of Facility	2004	Jaurer, D	e Lawar C				
å	permit. Departr Imports any inju	1 1	Short Funeral Home 700 West St. Laurel,	DE 199	56					
3			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resistock, or heart failure. List only one cause on each line.	piratory arrest,		Approximate Interval Between Onset and Death				
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Southe Sastrifit is third from one for the control of the	uze						
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P.O. Box	that the deaned by the a	Physician/Me	In the past 12 minutes / 1 ☐ Yes 2 Ø No 9 ☐ Unknown 5 ☐ Other (specify)							
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Division of Vital Records,	v require been sig should b			1 🗆 Yes	2 No 3 Pro	bably 4 Dunknown				
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<u>12</u>	ician: The certificate rector, pag	e Co	11/10 3.41.00	1□ Yes 2☑1		2 □ No				
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Div	al or A i after I Dirac d in by	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, Sta	ate)					
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ledical C		due to the cause t the time, date a	(s) and manner as and place, and due	stated. to the cause(s)				
	thin 24 thin 24 tha F	Med	29b. Signature and little of certifier 2		Date signed (Month					
	F \$ F 8		Akel Verlata Horosq318		2/24/6.	9				
	8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	21001	-1					
8D	4		31. Date filed (Month, Day, Year) 32. Registrar's Signature	21804						
	Si Regist	ate trar	31. Date filed (Month, Day, Year) FEB 2 6 2004 Security Signature Spaces							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra/MEND ITEM #26 PER PHY C830 2/29/04 Gertificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 18^{Day} MARCH 2004 9:05 P M MORRIS YOUNG EMTLY MARY 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **OUEEN ANNE'S** CORSICA HILLS NURSING HOME CENTREVILLE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG. 7, 1911 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 □ M 2 XF Months Days Hours DELAWARE Yrs. 92 220-28-4568 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State 1 ☐ Yes 2 🙀 No CENTREVILLE QUEEN ANNE'S 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number TISA 21617 1006 SPANIARD NECK ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LAUNDRY MANAGER -0-11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) EMMA OLIVE SLUSHER THOMAS PLENTY MORRIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1006 SPANIARD NECK ROAD, CENTREVILLE, MD 21617 GEORGE D. YOUNG/ SON 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4-1-2004 EASTON, MD WOODLAWN MEMORIAL PARK * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, entere 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) M. CARCINOMA PANCRGATIC METASTATIO Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No

Physician /Medical **Examiner**

Department of H
Important: If Ite
any injury or ot
once.

Physician

/Medical

Examiner

Funeral

Director

the

death

ed other than "natural", or items 23a or 28a-f ehow event, the Medical Examinar must be inclified at

Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. Int: If Item 27 Ie marked other than "natural", or Item

Baltimore, Maryland 21215-0036

Direct

Funeral

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Completed

The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit bit Vital Records, P.O. page 2 should be detached peen certificate or Attending Physician:

Box 68760.

Examiner Physician/Medical þ Be Completed

After death. within 24 hours after death To the Funeral Director: completely filled in by the

25. Was case referred to medical 27. Manner of Death

examiner?

1 Natural

2 Accident

3 Suicide

4 Homicide

1 ☐ Yes 2 ♣ No

Certification; To

Medical

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

26. Place of Death (Check only one)

Other: Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year) 016

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERIC R. CIGANEK, M.D., 2540 CENTREVILLE ROAD, CENTREVILLE, MD 21617

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28a. Date of Injury (Month, Day Year)

Registrar

31. Date filed (Month, Day, Year) 2004



the

g830 4/22/04 KB Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 2,8, per Dr. State of Maryland / Department of Health and Mental Hygiene 17,18 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 20 Day 1. Decedent's Name (First, Middle, Last) Month **Physician** 64EMAR MARC NANA AFUA SERWAAH /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner PRINCE GEORGES PRINCE GEORGES HOST CHEVERLY If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, v341)9/04 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1□ M 2 🗗 F Months Hours NONE. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County *how item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, it a Micdical Exeminational Le motified #1 19 Yes 2 No LANHANI PRINCE GEORGES Funeral Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 10011 GREENBELT RP. 20706 . Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: lited within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 AFRICAN AMERICA Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be itled within 7. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "ne sny injury or other traumatic event, It a Media 2006. Elementary/Secondary (0-12) College (1-4 or 5+) NONE-INFANT NONE - INFANT NONE KUNE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unknown Ramatu Kanu ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CANHAM, MO 20 706 RAMATU KANU-MOTHER IDUNI GREENBETT ROB City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State ' 4 Denation 5 ☐ Other (Speciff) 21. Signature of un fall ervice Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest x or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) Physician monare /Medical Que to (or as a consequence of) Examiner pirator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to for as a consequence of Examiner certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetel dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 ☐ Fetel death Year Month in the past 12 months? jo 4 Pregnant at time of death 5 Other (specify) signed by the and to be detached for P.O. F 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' 2 □ No certificate 2 No 1 Tyes 1 ☐ Yes 25. Was case referred to medical examiner?
1 Yes 2 100 26. Place of Death Check only one Be Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 3 DOA Silis safter death.
I Director After this d in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: Division tteriding 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or within 24 hours a To the Funeral L filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number 03-20-04 Trince George's Hespital Center who completed cause of death (Item 23a) (Type, Print) Cheverly 30. Name and address of pers Hospital Drive 31. Date filed (Month, Day, Year) APR 2 2 2004 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 10:10A 04 2004 **Physician** exson 03 arole /Medical 4c. County of Deeth 4b. City, Town, or Location of Deeth 4a. Fecility Name (If not institution, give street and number, **Examiner** Annapolis
If Under 1 Year
Months Days Arundel Anne Arundel Medical Center Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Min. Hours **Funeral** 1□M 2XF 65 Yrs. 30, 1939 Virginia 225-52-5904 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10b. County 10a. State 7 is marked other than "naturel", or Itema 23a or 28a-f ehow traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Arnold Maryland | Anne Arundel Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21012 101 Church Road Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ∏Yes 2 1 No f Yes, Give 72 hours after 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 ģ 3 ☐ Widowed 4 ※ Divorced Year or Dates: 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed e kind of work done du DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) II.S. Government <u>Administrative Assistant</u> 12 and Mental Hygie 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Myrtle Ernest Andrew Grev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health at
Important: If Item 27 is
any injury or other trau Morgantown, WV 26505 409 Lewis Street Cynthis Anderson / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Crematory 4/6/2004 Brentwood, Maryland A □ Donetion 21. Signature of Juneral Septite Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Michel 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 9 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mos una cancer Physician /Medical Due to (or as a consequence of): Examiner cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month Year in the past 12 poinths? ō 5 Other (specify) 4☐Pregnant at time of death the a o 9 Unknown detach 23e. Did tobacco use contribute to the cause of death? نے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ been signe should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autoosy certificate has t irector, page 2 s perions 2 \(\text{No} 1 Yes 1□ Yes 2 25. Was case referred to medical examiner? To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be Hospital: Inpatient Other: 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 70 2 No 2 ER/Outpatient 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Magner of Death funeral Certification: Alter Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No M death. neral Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

Kath 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		For Sta		State of Ma	arytanu /		e of Death	Mental Hyg	giene Reg. No. 2 (004	1214
;			dent's Name (First, Middle, La	ist)				2. Date of Dea	ath Day	Year	3. Time of Death
Physic /Medi		Ju	anita Nina Arc	cher				April	4	2004	8:20 P M
Exami		4a. Faci	ility Name (If not institution, giv	ve street and number)		4b. City	Town, or Location of Dea	ath	4c. Count	y of Death	
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Funeral			I Security Number 6.5	Sex 7. Ag 1 ☐ M 2, F	e (In yrs. last b	Months	r 1 Year If Under 24 Hr Days Hours Mir	n. (Month, Da	y, Year)	Cour	•
Director			70-54-3921	10 M 2001	82	Yrs.		Sept.	12, 19	21 Wes	st Virgini
pu .		Usuel F	Residence of Decedent ate 10b. County		10c. City, Tox	vn or Location				1	0d. Inside City Limit
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Ne M	Director	Ma 10 - St	aryland Monto	jonery	Bro	okville	o Code		10g. Citizen of	What Cour	ntry?
with the party of	급	100. 30	OSC ZING INGINIOSI								
be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Mcdical Exertitue must be notified at	by Funeral	21	03 Market Stre	12. Was Decedent	Ever in U.S.	13. Was Dece	20833 Ident of Hispanic Origin? Icify Cuban, Mexican, Pue	(Specify Yes or No	Uni ted		
ter d	15		Never Married 2 Married	Armed Forces?			Total Control	eno Hican, etc.)		ack, White,	etc.
urs af		7	Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 No Specify:		Spec	wh:	ite
2 hou	Completed		15. Decedent's E	Education	16	a. Decedent's Usi	ial Occupation ork done during most of w	vorkina	16b. Kind of	Business/In	dustry
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sicia	an		·				Month	Day	Yea	
edic	cal 🛭	Ruth Alberta Ande			4h City Town	or Location of Dea	April	5	2004	
min	er	4a. Facility Name (If not institution, giv Union Hospital of			Elkton	or Location of Dea	atn		County of De	eatn
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tor		215 32 3499 Usual Residence of Decedent	I	90 Yrs.	Months Days	Hours Mir	B. Date of Bir (Month, Da Decembe	r 8,	1913	Maryland
4		10a. State 10b. County		10c. City, Town or	Location					10d. Inside City L
	cto	Maryland Cecil		Elkton						1 Tes 2
	Director	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What (Country?
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	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		 Was Decedent of I If Yes, specify Cub 	Hispanic Origin? (pan, Mexican, Pue	Specify Yes or No irto Rican, etc.))-	 Race - An Black, Wh 	nerican Indian, nite, etc.
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njury or outer traumanc		19a. Informant's Name/Relationship (Bryan N. Anderson			iling Address (Street					. Zip Code) Maryland
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5		1 Burial 2 Cremation 3		North Ea	ematory or other pla st Method	ist Apr		Nort	h East	•
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra/mend#10c.Per FH PGC 4/1/04 cr Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 27, 7:54 P M ARMISTEAD March 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Laurel Regional Hospital Laurel Prince George's Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sax 5. Social Security Number 303-12-9340 **Funeral** 87 Months **№** M 2□ F AΚ Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a, State 10b. County 10c. City, Town or Location or iteme 23a or 28a-f ahow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hydene. Important: if Item 27 is marked other than "natural", or iteme 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 905e. 10615 Meadowridge Lane Mitchellville MD. 1X Yes 2 □ No Prince George's Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10615 Meadowridge Lane 20727 USA Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give 11. Marital Status Specify: Black 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: þ 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Cotlege (1-4or 5+) 2+ Elementary/Secondary (0-12) Private Minister 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mitchell Armistead Lydia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carol Awilda-Tatum, Daughter 10615 Meadowridge Lane, Mitchellville, MD. 20727 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 4/02/2004 Inglewood, CA. 1 XBurial 2 Cremation 3 Removal from State Inglewood Park Cenetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signa tire of Funeral Service Licensee Bianchi F.S. 814 Upshur St. NW Wash, DC 20011 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finat disease or condition resulting in death) Physician Respiratory Failure /Medical Due to (or as a consequence of). Examiner Pneummonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Acute Cerebral Vascular Accident and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4 Pregnant at time of death ☐Yes 2☐No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 1 ☐ Yes 🗶 ☐ No certificate Division of Vital Hoepital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No P this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After Injury 1 Katural 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cert

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) APR 0 1 2004

30. Name and address of person who cor

Yeheyis Negussie, MD 1111/Spring St. #214 Silver Spring, MD. 20910 32. Registrar's Signature

pleter cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** Rosa L. Alvarado MARCH 29.2004 6:06 p /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4315 NEWION STREET COLMAR MANOR PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 7, 1937 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□ M 2 F 216-70-9579 El Salvador 66 Yre Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23e or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 X Yes 2 ☐ No Maryland Prince George's Colmar Manor Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20722 4315 Newton Street El Salvador 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Specify: El Salvadoran Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Hispanic Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working other than Elementary/Secondary (0-12) College (1-4 or 5+) House wife Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked othe eny injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Delia Pena Rafae1 Naves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4315 Newton Street, Colmar Manor, MD Mariano Alvarado - Spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 X Removal from State General Cemetery 04/07/2004 San Salvador, El Salvador * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee au 4739 Baltimore Avenue, Hyattsville, MD Approximate Interval Between Onset and Death 23a. Part | Enter the disease, or complications 11-t cau to the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau on each line. Immediate Cause (Final disease or condition resulting in death) Physician nead Muries /Medical Due to (or as a cons an earlier of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 No page 2 s autopsy performed? 1 Yes 2□No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence & Other (Specify) AT SCENE 1 X Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 100 8b. Time of 28c. Injury at Injury O Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation tell down Steps 1. Natural 5:57Pm Sub, ect 1 ☐ Yes 2 🗷 No death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, Chart Town, State) 431 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide at home To the Hospital o within 24 hours aft To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME MARCH 30,2004 30. Name and address of person, who completed cause of death (Item 23a) (Type, $arrho 1_{11}$ Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)
APR 0 1 2004 82. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Vear **Physician** 3:35 pM 27, MARCH 2004 AYCOX **JEREMIAH** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year If Under 24 Hrs.

Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days 1₩ 2□F 79 Yrs. **GEORGIA** 422-18-5248 FEB. 1925 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐XYes 2 ☐ No ACCOKEEK PRINCE GEORGES MDDirecto 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20607 U. S. A. 101 BIDDLE ROAD or items 23a Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 No Specify: Maryland 21215-0036 3√2 Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) FEDERAL GOVERNMENT than Elementary/Secondary (0-12) College (1-4or 5+) Military Personnel Assistant 12 should be filed v h and Mental Hygie 7 Is marked other t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be DAISY WITCHER EARL AYCOX 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 101 BIDDLE ROAD ACCOKEEK, MD. Health a LINDA M. MINTER (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State ō 04-02-04 BRENTWOOD, MD. Ft. LINCOLN CEMETERY 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility W. H. BACON FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 3447 14th ST., N.W. WASHINGTON, DC 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmon a V Physician /Medical **Examiner** Sequentially list conditions, it any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a conseque P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∠ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page Stige 1 ☐ Yes 20-No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 2 ER/Outpatient 3 DOA 1 Anpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 ☐ Yes 2 ☐ No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0037066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6188 0 XIN Hill Rd #70 Oxon Hill, mo 20745 10 T. O Paigheogy, mo Uchechi 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

2004

Physic		1 - State Ragistrar Amend#26.Per I 1. Decedent's Name (First, Middle, Lass Jessie		Abraham			2. Date of De Month	Reg. No. 2 (Bath Day 19	3. Time of Death 5:12 p
/Med Exami		4a. Facility Name (If not institution, give				Location of Death		4c. Count	ty of Deeth
Funeral Director		230-80-1203	x ☐M 2 <mark>X</mark> F	In yrs. last birthday, 91 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	(Month, D	th Yeer) 3 12	9. Birthplece (State or Foreig Country) S. Carolina
a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County MD P. G		Oc. City, Town or L	ocation trict He	eights			10d. Inside City Limit
natural', or iteme 23a or 28a-f ehow deal Examiner : sust be notified at	Funeral Director	10e. Street and Number 6507 Kipling P	kwy		10f. Zip Code	20747		-	What Country?
natural', or Iteme 23a or 28a-f ehow dical Examiner: wat be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		ice - American Indian, ack, White, etc. ify: Black
Hygiene. other then "nature ent, the Wedical	Completed	15. Decedent's Eld (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)		dent's Usual Occup b kind of work done of DO NOT use retired Care Pro		rking	16b. Kind of E	Business/Industry ate
Mental arked c	To Be C	17. Father's Name (First, Middle, Last) Thomas Fogle					sa Mac	k	
= ~ =		19a. tnformant's Name/Relationship (7 Edward Abrahan		3706	ng Address (Street		uitlan	d, MD	20746
<u> </u>		20a. Method of Disposition 1 XBurial 2 Cremation 3 1 4 Donation 5 Other (Specify		20b. Place of Disp cemetery, cre Resurr	matory or other place	9 3-2	7 – 0 4		- City or Town, State
Important: If any injury or once.		21. Signature of Funeral Service Licens	E Col	n'a I	2. Name and Address Bonnette 2504 28t	& Assc	c. Fun	eral H	lome Inc.
Asician and wrial-transit aminer	Examiner	23a. Part1. Ever the disease, or compands, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	COYUMA	ny art	g, such as cardiac	or respiratory a	irrest,	Approximate Interval Between Onset and Death
by the attending phitached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	d	☐Fetel death 3	□Ectopic pregnancy □ Other (specify)				ate of delivery Ionth Day Year
signed d be de	by	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	underlying cause give	en in Part I.		lobacco use cor Yes 2 1XNo	ntribute to the cause of death? 3 Probably 4 Unknow
ate has page 2	Completed						24a. Was auto perfo 1 🗆 Yes		Were autopsy findings availabl prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
dire.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 DER/Outpatie	nt 3 DOA Oth	26. Place of Dea er: 4 ☐ Nursing H	ith (Check only		her (Specify)
death. ctor: Alter th y the funeral		27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day)	(ear) 28b. Time of Injury	Worl	/ at ⟨? Yes 2 □ No	28d. Describe	how injury occu	rred
Dir.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	r - At home, farm, st (Specify)	reet, factory, office		28f. Location (City or To		ber or Rural Route Number,
e Funeral letely filled	Medical	29a. Certifier 1 (☐ Certifying Phy (Check only 2 Medical Examone)	rsician: To the best of iner: On the basis of e and manner state	xamination and/or in	th occurred at the tin exestigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and m date and place,	nanner as stated. , and due to the cause(s)
To the	Me	29b. Signature and title of certifier			29c. Licensi		~	29d. Date sign	ed (Month, Dey, Year)
	i	6				D457 2	57	-	8118104

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2 \bigcap \bigcap \bigcup_{i}$ 1 - Stete Registrar AMEND#7 per FH3/30/04, EMW, McCo Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2004 Month 9:24 AM M **Physician** James Anderson, Jr. March 20, /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Southern Maryland Hospital Prince George's Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year March 24, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs_last birthday) **Funeral** Year) Days Hours 1√2 M 2□ F 244-23-9323 1947 Guilford, NC Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show other traumatic event, the Medical Exercit er trust be notified at 1 ☐ Yes 2 ☑ No Director Prince George's Suitland 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ŏ 5407 Auth Road 20746 USA or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. I □Yes 2) No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. timore, Maryland 21215-0036 Specify: Completed by Black 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) then Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Janitorial Service 12 es 1 and 2 should be filed w of Health and Mental Hygier I itam 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Margie Leach James Huntley Anderson, Sr. ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary E. Anderson (Wife) 10 Rehobeth Ct., Greensboro, NC 27406 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages i 1 □ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 ₺ Other (Specify) Entombment Guilford Memorial Park 3/28/04 permit. Pages Department of Important: If it any injury or o Greensboro, NC 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility
Woodard Funeral Home O'Henry Greensboro, NC 27405 3200 N. Blvd. 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or espiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cowas **Physician** /Medical resulting in death) Due to, **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury use as the burial-transit Hospitel or Attanding Physician: The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day funeral director, page 2 should be detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed? 1 Yes 2/2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient Certification: To Yes 2□ No 1 Inpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1-Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be determined 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated To tha 29b. Signature and vitle of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 43606 04 elemin.

3

Ope Sami, M.D. Registrar

31. Date liled (Month, Day, Year) MAR 3 0 2004

7503 Surratts Rd., Clinton, MD 20735 32. Begistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		4	For State Registrar	State of Ma	•	epartment of a Certificate of			ene 2004	12149
Ė			Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia	_	Joanna Fotos Apost	16				March 2		9:45 P ^M
	/Medic Examin	_	4a. Fecility Name (If not institution, give st	reet and number)		4b. City, Town,	or Location of Death		4c. County of Deat	h
			15101 Interlachen	Dr, #124			r Spring	T	Montgomer	
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birt	hday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, 1		hplace (State or Foreign untry)
ь	Director	, }	246-50-1408 Usuel Residence of Decedent		68	113.		Apr 11,	1935 No	rth Carolina
1	and w		10a. State 10b. County		10c. City, Town	or Location		-		10d. Inside City Limits
	-i-h	to	Maryland Montgome	rv	Silve	r Spring				1 □ Yes ZĄŪ No
1	r 28a	Director	10e. Street and Number	<u>. y</u>		10f. Zip Code		10	g. Citizen of What Co	untry?
-	23a o		15101 Interlachen	Dr, #124		20906			USA	
-	ems er m	Funeral		Was Decedent E Armed Forces?		 Was Decedent of if Yes, specify Cu 	Hispanic Origin? (Sp ban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, White	
2	or it	by Fu	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 ☒ No	Specify:		Specify:	
į	Tural'	q pe	15. Decedent's Educa		16a.	Decedent's Usual Occi	upation	10	6b. Kind of Business/	nite Industry
2	n /2	olete	(Specify only highest grade	completed)		(Give kind of work done life. DO NOT use retir	during most of work	king		,
7	iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-		omemaker			Own Home	2
2	othe vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	aiden Sumame)	
9	uld by Menta Irked Itic e	TO E	Peter Pappas					Chamis		
<u>a</u>	2 should be filed within 72 hours after death with the maryland and Mental Hygiene. and Mental Hygiene. It marked other than "natural", or Items 23s or 28s-f show aumstic event, the Medical Exacult or mark the notified at		19a. Informant's Name/Relationship (Typ		1	Mailing Address (Stree				
. Z	and ealth m 27		Pauline C. Fotos/D	aughter		503 J. Carr Disposition (Name of			lver Sprin Oc. Location - City or	Town State
	1 0 H 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		20a. Method of Disposition 1 🖾 Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cemeter	y, crematory or other pl	ace)			
Saitimor	trant:		' 4 □ Donation 5 □ Other (Specify)	- 4	Gate o	of Heaven C		29, 2004	Silver S i Funeral	Spring, MD
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show eny injury or other traumatic event, the Medical Examination mast be notified at once.		21. Signature of Funeral Service License	e centre						ng, MD 20904
.0	4		23a. Part1. Enter the disease, or complice shock, or heart allure. List only one	ations that caused cause on each lin	the death. Do	not enter the mode of dy	ring, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
į. F	Physician		Immediate Cause (Final disease or condition		Carcino	oma of Lung				Oriset and Death
	/Medical Examiner		resulting in death)	Due to (or as	consequence	of):				
	·	_	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence	of):				
	led nsit	nln	Cause (Disease or injury	200 10 (0. 20						
	al-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as	a consequence	of):]]
8/PU	cate be executed physician and the burial-transit	20	d							
		Medic	IE EELIAI E.							
X Q Q	ires that the death certifi signed by the attending d be detached for use as	ician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	lc. If yes, outcome 1□Live birth	2 Fetal death		су		23d. Date of del Month	ivery Day Year
O.	e dea the at ned fo	sici	1 Yes 2 No 9 Unknown	4□Pregnant at 9□Unknown	time of death	5 ☐ Other (specify)				,
Į.	hat the od by the detache	Physi	Part II. Other significant conditions con-	ributing to death be	ut not resulting i	n the underlying cause of	liven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ďS,	requires that leen signed b hould be deta	d by						1 🗆 Yes	s 2 ⊠ No 3∏Pr	robably 4 Unknown
Hecord		Completed						24a. Was an	24b. Were au	utopsy findings available
ĕ	sician: The law certificate has b rector, page 2 st	dm						autopsy perform	ed? prior to death?	completion of cause of
_	in: T	C	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2		2 NO
	Physician: this certific ral director,	0 8	examiner?	ospital:	nt 2 ER/O	utpatient 3 DOA			nce 6 Other (Spe	cify)
סנ	ig Physter this seral di	T:U	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injui	y Year) 28b.	Time of 28c. In		28d. Describe how		
<u>0</u>	ath. oath. or: Af	atic	2 Accident investigation			M 1	Yes 2 No			
Division	r Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury · At home, fa c. (Specify)	arm, street, factory, offic	9	28f. Location (Str. City or Town,	eet and Number or Ri State)	ural Route Number,
	urs at urs at eral D		on O office 153 Continue Dhus	inion. To the best	-4 (o death assured at the	time, data and place	and due to the co.	upo(a) and manner as	n stated
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the Completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medicel Exemin	ier: On the basis of and manner sta	examination ar	e, death occurred at the id/or investigation, in my	opinion, death occu	rred at the time, da	te and place, and due	e to the cause(s)
	o the	Me	29h Signature and title of certifier				nse number	29	d. Date signed (Mont	
	- Š-Ů		1 manien	R Ho	itar 1	no 04	7950		03/26	12004
	V7/		30. Name and address of person who co	mpleted cause of d	eath (Item 23a)	(Type, Print) 1930	E. Manun	nent Stre	et. Suite	50U
			Maureen R. 1	tortor	1. mr) Bal	timore.	marylar	12 21205	
		ate	31. Date filed (Month, Day, Year) MAR 3 0 200		ar's Signature	& Soon				
	Regist	rall	WIAK 3 U ZUL	14	-	~ apour				

State of Maryland / Department of Health and Mental Hygiene 200 L Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>004</u> Month **Physician** March 28, Marija Avramovic 11:50 P ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Casey House Montgomery Hospice Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 26, 1920 Yugoslavia Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2K F 218-52-7691 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 8how 10a. State ir than "natural", or Items 23a or 28a-f shov 1X Yes 2 □ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13200 Cleveland Drive 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filad within Department of Health and Mental Hygiene. Important: If item 27 is marked othar than any injury or othar traumatic avant, the Me Elementary/Secondary (0-12) College (1-4or 5+) 4 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rista Jovanovic Evtalija Jovanovic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Zoran Avramovic/ Son 13200 Cleveland Drive, Rockville, MD 20850 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Belgrade, Yugoslavia New Cemetery ¹ 4 □ Donation 5 □ Other (Specify) unknown 21. Signature of Funeral Service Lice 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 23a. Fartt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or fleet failure. List only one cause on each line.

Immediate dause (Final disease or condition and death)

Advanced No. 17 ville, Inc. 300 West Montgomery Rockville, Maryland 20850-2805 Avenue, Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) Over 6 Months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medicai as the l IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: $_{4}$ Nursing Home $_{5}$ Residence $_{6}$ Cother (Specify) Hospice 2 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attanding 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 3 T Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide tha Funeral 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

20 License pumpler. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and tip 2 nd address of person who completed cause of death (Item 23a) (Type, Print) Charles M. Harrison, M.D. 6001 Muncaster Mill Road, Rockville, Maryland 20855 31. Date filed (Month, Day, Year) MAR 3 0 32. Pagistrar's Signature souks 22mer Registrar

AVramovie

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March **Physician** 27,2064 Audrev Allen 9:18pm M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 04/19/1931 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 1 F North Carolin Director 72 245 48 9245 Usual Residence of Dec 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow Examiner must be notified at Hyattsville 1 XYes 2 No Director Prince George Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20783 Items 23a 823 Cox Ave death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 end 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 🔀 No Specify. Specify: Black 3 Widowed 4 Divorced ear or Dates: "natural", the Medical Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 le marked other than eny injury or other treumatic event, the Manger. Government Clerk 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Viola Martin John L. Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 823 Cox Ave Hyattsville, Md 20783 Carlton C.Allen Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans 4/5/04 Cheltenham, Maryland *4 Donation 5 Dother (Specify) Spead Funeral Home & Cremation Service 5732 Georgia Ave NW Washington, DC 20011 21. Signature of Funeral Service Licensee Jan 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a co Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequer attending physician for use as the buries P.O. Box 68760. Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No death. tilled in by the f 2 Accident 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) Tol 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Nasreen Kango, M.D. 7600 Carroll Ave Takoma Park, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 31 2 By Back MAR Régistra

Alejandro Cesar Aguilera Unknown 04-095 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-02116 State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registra DOS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Yeer **Physician** Alejandro Cesar Aquilera MARCH 27 2004 0248 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9309 Adelphi Road Adelphi Prince Georges If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 15€M 2□ F 213-39-6995 24 Director May 5, 1979 Nicaragua Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at MD Montgomery Silver Spring 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 804 Northampton Drive 20903 or Items 23a Nicaragua Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ☐Yes 21 No Maryland 21215-0036 152 Yes 2□ No f Yes, Give Year or Dates: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced "naturel", Nicaragua 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 unemployed none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be t nent of Health and Mental I ant: If Item 27 is marked or Socorro C.Alejandro Aguilera Sabina Aguilera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sabina Aguilera/Mother 804 Northampton Dr. Silver Spring Md 20903 ce of Disposition (Name of Date 20c. Location - City of Town, State Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nicaragua 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If I any injury or once. La Piadosa Cemeterio4/05/04 Chichigalpa, 21. Signature uneral Service Licet PHILIP D.RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring Md20010 enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Completed by Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Year Day 4⊡Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. detached 9 Unknown 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, should be PRINO 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No 24a. Was an page 2 autopsy performed? 1 Yes 2 No of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one ToF Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Hother (Specify) at scene 1 XYes 2 No in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 2 Accident 27/64 2:07 4 1 ☐ Yes 2 XNo death. Diver at Auto involved in collision after death Director: 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number City or Town, State) 9309 Rule In (CCR) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide filled within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) March 27 2004 OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 MARY G. MPRIEND JACK 31. Date filed (Month, Day, Year)
APR 0 1 32. ₽egistrar's Signature State 2004

Registrar

			1 - For State of Maryland	I / Depa	artment of H	lealth and	Mental Hy	giene 200	4 12153
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	Tillicate of t	Jeam	2. Date of De	Reg. No. C- U U	3. Time of Death
	Physicia	an					Month	Day Yea	1
	/Medic		JACK PERSHING AHALT 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deat		20 , 20 , 20 4c. County of De	04 11:07 P M
	Examin	er							
	Funeral		Clearview Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday)	Hagersto	If Under 24 Hrs			on County irthplace (State or Foreign Country)
	Funeral Director		216-30-3050 ^{1⊠M 2□F} 69	Yrs.	Months Days	Hours Min			country) ryland
-	- 1	j ,	Usual Residence of Decedent			1	1100.	171554 114	16.
	rylan tat		10a. State 10b. County 10c. City,	, Town or Lo	cation				10d. Inside City Limits
	e Ma	cto	Maryland Washington Co. Had	gersto	wn				1 ☐ Yes 2 ☑ No
	death with the Maryland	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What (Country?
	ath w	ra	20009 Rosebank Way		21742			U.S.A.	
	er de Items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	i. 13. V	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer	Specify Yes or No to Rican, etc.)	5- 14. Race - An Black, Wh	nerican Indian, nite, etc.
5	hours after tural', or Ite	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	1	1 ☐ Yes 21☑ No	Specify:		Specify: W	hite
-000	tura stura		15. Decedent's Education	16a. Deced	dent's Usual Occupa	ation		16b. Kind of Busines	s/Industry
<u>.</u>	within 72 ene. than "nai	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give lite. [kind of work done of OO NOT use retired	during most of wo ()	rking		,
7	d with	Completed	10	Iron	Worker			Local Unio	on
and	be filed within 72 hours after death with the Marylan Hygiene. d other than "natural", or liems 23a or 28a-f show event, tra Medical Examinat must be rediffed at	Be	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle	, Maiden Sumame)	
Z		70	John Ahalt			Florence	e Daymud	e	
O	2 should be and Mental is marked of raumatic ev		19a. fnformant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street a	and Number or R	urai Route Numb	er, City or Town, State,	Zip Code)
ב פ	s 1 and 2 should of Health and Mer Item 27 is marke other traumatic		Crystal A. James/ Daughter 20a. Method of Disposition 20b. Pla	17507	Taylors	Landing	Rd. Sha	rpsburg, M	D 21782
	Pages nent of thint: if lite		I E-Dural 2 Cremation 3 Nemovariion State		sition (Name of natory or other plac		Date		
Бапппо	iit. Pag urtment urtant: i niury o		*4 Donation 5 Other (Specify) Ced 21. Signature of Foneral Service Licensee		n Mem. P		23,200	4 Hagersto	own, Maryland
מ	permit. Pages Department of Important: If It any injury or once		Paula De Paula IV	7		Do	ouglas A	. Fiery Fu	neral Home
			23a. Part1. Enter the disease, or complications that caused the death.					erstown, M	Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final						Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Arterio Scle Due to (or as a consequi	≥rotic ence of):	Cardio V	<i>l</i> ascular	Disease		
	Examiner		Sequentially list conditions b						
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	∍nce of):					
	be executed ician and burial-transit	хап	that initiated events resulting in death) Last Due to (or as a consequence)	ence of):					
0	ate be executed hysician and he burial-transit	calE		,					
	ficate g phys		a						
POX	anding use a	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant)Catania			23d. Date of d	elivery
Ď	death e atte	icla	in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
r Ö	The law requires that the death certifica site has been signed by the attending ph bage 2 should be detached for use as th	Physiclan/Med	9 🗆 Unknown						
S,	igned be de	by	Part II. Other significant conditions contributing to death but not result Parkinsons Disease, Carcinoma					obacco use contribute	
Vital Hecords,	requi	Completed	Tarkinsons bisease, caremona	W1011	, myper ce	3131011		Tes 2 No 3 F	Probably 4 Munknown
၁	2 2 2	nple				·	24a. Was		autopsy findings available completion of cause of
							1 ☐ Yes	2 x No 1 □ Ye	s 2 No
<u> </u>		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ E	D/O-45-4-	Othe)r	ath (Check only o		
	Phys ar this aral di	-	27. Manner of Death 28a. Date of Injury 2	28b. Time of				dence 6 Other (Sp how injury occurred	өсіту)
5	Attending ir death. ector: Afte by the fune	atloi	1 ☑ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Infury		(? Yes 2 □ No			
DIVISION	Atte	tifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (City or To	Street and Number or F	Rural Route Number,
5	tal or rs afte al Dir ed in	Certification:	Salari gi ota (apoen)				0.1, 0.70		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical	29a. Certifier 1 SCertifying Physician: To the best of my know (Check only 2 Section 1 Medical Examiner: On the basis of examination one)	rledge, death on and/or inv	occurred at the time restigation, in my op	e, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License	number		29d. Date signed (Mor	oth, Day, Year)
	,		2 to MI		D180	19		March 21,2	004
, 1	4		30. Name and address of person who completed cause of death (ftem	23a) (Type, í	Print)				
2	\ -		Vasant Datta MD 340 Mill Stree		gerstown,	MD 217	40		
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 3 2004 32. Registrar's Signatu	B. D.	perke				

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					State of h	naryia				reaim and Death	i Mentai Hy	rgiene Reg. No. 2 (nnı.	10151
			1. Decedent's Name (Firs	t, Middle, Last)						2. Date of D	eath		3. Time of Death
-	Physicia /Medic		BRUCE HAU	PT Al	LEXANDER						MARCH	31, Dey 200	Year 04	12:12 P.M.
_ /	Examin		4a Facility Name (If not in			r)			4	lb. City, Town, o	r Location of Dea	th 4c. Count	y of Death	
			WILLIAMSPOR					lf (la	las 4 Vana		AMSPORT		WASHI	
П	Funeral		5. Social Security Number	15	x 7.7 ∄M 2□F		i. last birthday) Yrs.	Month	er 1 Year s Days	If Under 24 Hr Hours Mi	n. (Month, D			place (State or Foreign htry)
	Director		215-20-9019 Usual Residence of Dece			90	110.				<u>JAN.</u> 3	L, 1914	MAF	RYLAND
	faryland ehow		10a. State 10b.	County		10c. C	city, Town or Lo	cation				-	1	0d. Inside City Limits
	Mar	ģ	MARYLAND W	ASHING	ΓON				HAG	ERSTOWN				1⊠ Yes 2□No
	15 P	Director	10e. Street and Number			•		10f. 2	ip Code			10g. Citizen of	What Cour	ıtry?
	23a	la l	27 LEHIGH A	VENUE					21	742		Ţ	J.S.A	•
	tems terms	Funeral	11. Marital Status		 Was Deceder Armed Forces 	?	U,S. 13. V	Vas Dec Yes, st	edent of H ecify Cuba	ispanic Origin? (n, Mexican, Pue	Specify Yes or Norto Rican, etc.))- 14. Ra	ce - Americ	
20	rs aft	by F	1 ☐ Never Married 2 3 ☑ Widowed 4 ☐ D		1 ☐ Yes 2 ½ If Yes, Give Year or Dates		1	□Yes	2 √ No	Specify:		Specif		
21215-0020	72 hours after death with the Maryland "natural", or flems 23a or 28a-f ehow adical Examiner must be notified at	8		ecedent's Edu			16e. Deced	ent's Us	ual Occupa	ation		16b. Kind of B	7722	<u>IITE</u>
215	c . 9	Completed	(Specify onf	highest gred	College (1-4o	54)	(Give I lite. D	kind of v OO NOT	vork done d use retired	furing most of w	orking			,
2	filed with Hygiene. ther ther ent, the	ĕ	8	(0 12)	Conlege (1 40)	3+)			FOREM	AN		STATE F	II.GHW	AY ADMIN.
nd		Be	17. Father's Name (First,	Middle, Last)						18. Mother's Na	ame (First, Middle			
yla		To Be	LAWSON CLIF								FLORENCE			
Maryland	2 sh and ie m	1	19a. Informant's Name/Re								Rural Route Numb			Code)
	s 1 end f Health tam 27 other tr	-	NELSON K. A 20a. Method of Disposition		ER/SON	20h	31 LE			NUE, HAG	GERSTOWN Date			21742
Baltimore,	80= 5		1 ⊠ Burial 2 □ Crer	nation 3 🗆 R	emoval from Stat		cemetery, crem	atory of	other place	e)	Date	20c. Location	City or ro	wn, State
틆	Departmen Departmen Important: Iny Injury DICE.	1	4 Donation 5 C	/ / /		BC	ONSBORC			Y 2	4/3/04	LOONSE	RO, N	1ARYLAND
Ba	Depri Impo	3			SAL					AL HOME	7606 0	ld Natio	mal I	ike
	-	-	23 Part 1 Inter the dise	Kê		immer	man				Boonsb	oro, Mar	yland	21713
4	Physician		23 Part1 Enter the dise shock, or he in failui	e. I st only o	e cause in each	line.	un. Do not sinte	, the m	de or dynn	y, soon as cardiz	ic or respiratory a	11651,		Approximate Interval Between Onset and Death
H	/Medical		Immediate Cause (Final disease or condition		Bilate		Preu	IAA KM	400				1	10 DAYS
В	Examiner -		resulting in death)	а	· Perior		or as a consequ							00015
Т	D #	Examiner		-									1	
J	tificate be executed g physician and as the buriel-transit	E	Sequentially list condition			Dua to (or as a consequ	ianue ul).					
60,	be eg ician burie	<u>a</u>	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	" / 。			<u>,</u>		20000					
68760,	icete phys s the	edical	that initiated events resulting in death) Last	1		Due to (or as a consequ	ence of	:					
	nding use a			٥										
P.O. Box	The law requires that the death cer ete has been signed by the attendin page 2 should be deteched for use	Completed by Physician/N	Part II. Other significant o	onditions con	tributing to death	but not res	sulting in the un	derlvina	cause give	n in Part I.	23b. Did	lobacco use co	ntribute to	the cause of death?
<u>о</u>	at the by the	٦	DIABOR	Mr.	= (. (, ,				Yes 2⊠No		ably 4 Unknown
	es the	2	DIABETES	MELLI.	1005									
Division of Vital Records,	een s	ge	SENIE E	DEMEN	ITIA						24a. Was perfo	an autopsy rmed?	ava	re autopsy findings ilable prior to
Sec.	has b		201010	Cirio	01111									npletion of cause leeth?
a	i: The										1 🗆 '	res 2 No	1 🗆]Yes 2□No
<u> </u>	Attanding Physician: or death. sector: After this certific by the funeral director.	ן מ	25. Was case referred to r examiner?	100	ospitel:				Othe Othe	THE PARTY OF THE P	ath (Check only o	,		
ō	Phys rthis aral d	0	1 ☐ Yes 2 🔯 No 27. Manner of Death		28a. Date of Inj	urv	ER/Outpatient 28b. Time of		OA	4 KU Nursing I	Home 5 ☐ Resident	lence 6 □Oth)
on	th. : Afte			Pending investigation	(Month, D	ay Year)	Injury	м	28c. Injury Work 1 ☐ Y	? ′es 2 □ No		ion injury cocurr	00	
Vis	Attar or dea octor by th			Could not be determined	28e. Place of In	jury - At h	ome, farm, stre	et, facto	ry, office		28f. Location (Street and Numb	er or Rural	Route Number,
Ö	s after safter all Dir	Certification:	4 Nomicide		building, e	іс. (Зресп	'y)				City or To	m, State)		
	tospit t hour unerri		29a. Certifler 1 ☑ Co (Check only 2 ☐ M	ertifying Physi edicat Examin	cian: To the best er: On the basis of	of my kno	wledge, death o	occurre	at the time	e, date end place	e, and due to the	cause(s) and ma	nner as sta	ited.
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		U1107		and manner s	tated.								
	5 ½ 5 ½		29b. Signature and title of	A) I I I A				29	c. License	number		29d. Date signed	ı (Month, D	ey, Yeer)
			YSY	m	•			6	755	100		MARCH.	31,2	2004
	44	1	30. Name and address of p	erson who cor					(DI+T)-	and.	7:7/	e-		
0	State		1ED HOWE 31. Date filed (Month, Play	Yearl.	32 Paniet	rar's Signa	ST, WILL	44211	STURI	, 0001	2179	5		ν'
	Registra		APR	02 20	14 Janes	ر میں	1. Sp	when	/					

DHMH 16 Rev 6/95

		. For State	e of Maryland / Depa	artment of Health and M	_	ene	10155
		- State Registrar	Cei	rtificate of Death		3. No. 2004	1 5 1 0 0
Physic /Med		1. Decedent's Name (First, Middle, Last) Kathryn Pearl Bass			2. Date of Death Month March 22		3. Time of Death 11:07 A M
Exami		4a. Facility Name (If not institution, give street and 3750 Elliott Island Ro		4b. City, Town, or Location of Death		4c. County of Death Dorcheste	
Funeral Director		5. Social Security Number 212-10-3278 6. Sex 1 □ M 2 ☒	7. Age (In yrs. last birthday)	if Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Sept. 13	year) 1913 Mar	nplece (State or Foreign untry) 'y Land
aryland	<u></u>	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
or 280-1	Director	Maryland Dorchester 10e. Street and Number	Elliott	10f. Zip Code	10	g. Citizen of What Co	untry?
ath w	rai	3750 Elliott Island R		21869	anit . Van au Na	USA 14. Race - Ame	ncan Indian
if e, Midi yidiliu Z IZ IS-0030 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "netural", or items 23e or 28e-f show other traumatic event, the Midical Examine Living be incilling at	by Funerai	1 Never Married 2 Marned 1 Yes	es 2DXNo	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White	White
2 hou		15. Decedent's Education (Specify only highest grade comple		dent's Usual Occupation kind of work done during most of work		6b. Kind of Business/	industry
within 7 liene.	Completed		ge (1-4or 5+)	DO NOT use retired) keeper		Nomen's Who	olesale Shoe
other	BeC	17. Father's Name (First, Middle, Last)			e (First, Middle, M		
Vial Menta Arked arked	To	John Wesley Gray		Pearl Ber			
Mar d 2 sho th and 7 is m traum	1	19a. Informant's Name/Relationship (Type, Print, Leonard D. Zeller/Fune	1	ng Address (Street and Number or Rur Box 207, East Ne			
tem 2		20a. Method of Disposition	20b. Place of Dispo			Oc. Location - City or	
Dallinofe, Maper permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other fra		1 ☐ Burial 2 【③Cremation 3 ☐ Removal f `4 ☐ Donation 5 ☐ Other (Specify)	Crematory	of Delmarva 3/23,	/2004 De	elmar, Del	aware
Demit Depart Impor		21 Entrative of Fineral Service Lickly ee	Teller Ze	2. Name and Address of Facility 211er Funeral Home 06 Main Street, Ea	,P. O. Bo	ox 207 arket, MD	21631
		23a. Pan . Enter the disease, or complications t shock, or heart failure. List only one cause Immediate Cause (Final	hav caused the death. Do not ent	ter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
Physiciar /Medica Examine	1	disease or condition resulting in death)	e to (or as a consequence of):	y sohy Home			10 minures
ed sit	liner	Saturatially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e to (or as a consequence of):				
bu, be executed sician and burial-transit	al Examin	that initiated events c.	e to (or as a consequence of):				
66/6 ificate by physicas the b		d					
hat the death certificate of by the attending physical detached for use as the	Physician/Medic	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
<u>ග් ම ලි</u> සි	þ	Part II. Other significant conditions contributing	to death but not resulting in the u	underlying cause given in Part I.	23e. Did toba	acco use contribute to s 2 ☑ No 3 ☐ Pri	
- D 75	etec				24a. Was an		topsy findings available
e lay	Completed				autopsy perform	prior to d	completion of cause of
VITAL P vician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			h (Check only one)	-
OT VITA Physician: r this certific	2		1 ☐ Inpatient 2 ☐ ER/Outpatien Date of Injury 28b. Time of		ome Resider 28d. Describe how	nce 6 Other (Spec	cify)
	tion	1 Patural 5 Pending Accident investigation	(Month, Day Year) Injury	of 28c. Injury at Work? M 1 □ Yes 2 □ No		,,	
DIVISION at or Attending atter death. I Director: After	ertification:	3 Suicide 6 Could not be	Place of Injury - At home, farm, st building, etc. <i>(Specify)</i>	reet, lactory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	iral Route Number,
To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	edical C	(Check only 2 Medical Examiner: On		th occurred at the time, date and place, nvestigation, in my opinion, death occur			
To the within 2 To the complet	Me	29b. Signature and title of certifier	/	29c. License number	29	d. Date signed (Month	h, Day, Year)
		I mymed /en	no	1451793		3/23/04	/
		30. Name and address of person who completed	I cause of death (Item 23a) (Type,	So3 Byn	ot Car	mbridge.	MD 21613
Regis	itate	31. Date liled Month, Day Year) 2 5 200	32. Registrar's Signature	back			

		•	For Stete Registrar	State of I	Maryland		artmen rtificate			and M	-	giene Reg. No. (200	4 12	156
	Physici	an	1. Decedent's Name (First, Middle,	-							2. Date of De Month	ath Day	Year	3. Time of	Death
	/Medic		Margaret		nana	^					3	24	04	1641	M
7	Examin		4a. Fecility Name (If not institution, Region	/ .		actor	4b. City,	Iown, or	Location o	Death		4c. C	ounty of Dea	MICO	
-	Funeral				Age (in yrs. is	ast birthday)	If Under		If Under		8. Date of Bir (Month, Da	th	9. Bi	rthplace (State o	r Foreign
п	Director		219-14-3905	1□M 2 X 1F	78	Yrs.	Months	Days	Hours	Min,	August 1	4,1925	1	ginia	
	pu 🛊		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation							10d. Inside Cit	ty Limits
	Aaryla f sho	ō												1 🗆 Yes	-
	the N	Director	Maryland Worces 10e. Street and Number	ster	P	ocomok	10f. Zip					10g. Citize	n of What C	ountry?	
	ous atter death with the Maryland rat', or items 23a or 28a-f show Exan in crinust be inclitted at	ΙD	1826 Cedar Hall	Poad			218	851					USA		
		Funerai	11. Marital Status	12. Was Decede	ent Ever in U.S	S. 13.			spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)			erican Indian,	
36	hours after tural', or Ite	by Fu	1 Never Married 2 Marrie	ld 1 ☐ Yes 2 (X No	1	1 ☐ Y <i>e</i> s 2		Specify:	,			pecify:	White	
21215-0036	"natural"		3 Widowed 4 Divorced	Year or Date	s:	16a Dece	dent's Usua	I Occupa	ation			16h Kind	of Business	s/Industry	
15	.⊆ ~ ₩	piet	(Specify only highest Elementary/Secondary (0-12)		25.54)	(Give life.	kind of wor DO NOT us	rk done d se retired)	uring most	of worki	ng	TOD. TURN	or Business	a industry	
212	d within giene. ar than "	Completed	12	2	or 5+)	Secre	etary					Publ	ic Sch	nool	
	be filed ntal Hygis ed other event.	Be (17. Father's Name (First, Middle, L.								(First, Middle,		_		
<u> </u>	shoutd be nd Mental marked o	၉	Thomas Hayes		n	405 14-75	- A d d	(0)1		ary	DeLi			ams	
Maryland	d 2 h a 7 is	1	19a. Informant's Name/Relationshi William E. Buc		n))					al Route Numbe on, Mar				
	1 an Heal Iem 2		20a. Method of Disposition	nanan (50	20b. PI	ace of Dispo	sition (Nam	ne of	1		Date Page	_		r Town, State	- 1
OM	Pages ent of nt: If it		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		110	emetery, crei st Bapti			·	arch	30, 2004	Poco	moke (City,Mar	vland
Baltimore,	permit. Pages Department of Important: If it any injury or o	1	21 Signature of Funeral Service Li											sional A	
m	8 9 E E 8		Michael A	Dean			101 LOW	nder	Aver	i rui iue,	Pocomo	ke Ci	ty, Ma	aryland	21851
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that cause nly one cause on each	sed the death h line.	. Do not ent	er the mode	e of dying	j, such as	cardiac c	or respiratory ar	rrest,		Approximate Interval Bety	w <i>ee</i> n
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	V	Hlun	ple	tra	unc	_	compli	cati	ons	Onset and I	J e ath
1	/Medical Examiner		resulting in death)	Due to (or	as a consequ		· A.								
		ē	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequ	M ∨ ence of):	H								
	outed id	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c											
o,	be executed sician and burial-transit		resulting in death) Last	Due to (or	as a consequ	ence of):									
8760	ate hys	dicai	'	d								-			
9 X	eath certific attending p for use as	/Me	IF FEMALE:	23c. If yes, outcor	me of pregnar	ncv	-					22	d Data of da	là con c	
Box	atten atten	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth	n 2 □ Fetal t at time of de	death 3	Ectopic pro					230	d. Date of de Month	•	/ear
P.O.	it the de by the	hysi	9 Unknown	9□ Unknowr	n										
	es tha igned I	by P	Part II. Other significant condition		h but not resu	Iting in the u	nderlying ca	ause give	n in Part I.				4	o the cause of d	eath?
ord	v require been si should l	ted	Pelvic Fr	ne							101	res 2	No 3□P	robably 4 🗆 U	inknown
Vital Records,	law r nas be	Completed	felvic Fr	suture							24a. Was autop	SV	24b. Were a prior to	utopsy findings a completion of ca	available ause of
A H												2 No	1 Yes	2 No	
Z.	Physician: Th rthis certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital:		-0.0		. Othe			(Check only o				
of	g Phys ter this neral dii	\vdash	27. Manner of Death	28a. Date of I	njury	ER/Outpatier 28b. Time of		8c. Injury Work	at Nur		n <i>e</i> 5 ☐ Resid 28d. Describe h			ecify)	
ion	Attending r death. actor: After by the fune	atioi	1 □ Natural 5 □ Pending 2 ☑ Accident investiga	- 1 - 1 - 1	Day Year)	Injury	М	Work	? ′es 2. ⊠ 1∜	10	MV	IC			
Division of	l or Attend after death Diractor: A	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		Injury - At hor	me, farm, str	eet, factory	, office		2	28f. Location (S City or Tox	Street and I vn. State)	Number or R	ural Route Numi	ber,
	ospital or A hours after unaral Dira ly filled in b	Cer			Street	r					RT13/Tul	is Rd		ote MD	
	工本正品	ledical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physicien: To the be xeminer: On the basis and manner	s of examinati	vledge, death ion and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a h occurre	and due to the d ed at the time, o	cause(s) ar date and pl	nd manner a ace, and du	s stated. e to the cause(s))
	To the within 2 To tha complet	Mec	29b. Signature and title of certifier	andmanner	Stated.			License	number			29d. Date s	signed (Mon	th, Day, Year)	
	0 = 0 0						29c	1001100							
	To vitil		I Com Son	all when					497			3/2	7/04		
	To To cor		30. Name and address of person w	tho completed cause of	of death (Item	23а) (Туре,	Print)	450	497			3/2	1		
E.	T 3		30. Name and address of person with the Carroll St. 31. Date filed (Month, Day, Year)	Salis buy	of death (Item	218	Print)	450		inde	v D.o.	3/2	1		

			State of Ma	aryland / De	partment of bertificate of	Health and M	lental Hygi	•	12157
•	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) WILLIAM 4a. Facility Name (If not institution, give street and number) Atlantic General Hosp	W.	BUMPUS 4b. City, Town, o Berli	or Location of Death	2. Date of Death Month 3	Day Year 24 2004 4c. County of Deat	
35	Funeral Director			e (In yrs. last birthda 76 Yrs	Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, 8 – 29 –	Worces Year) 9. Bird Co 27	hplace (State or Foreign untry) KY 10d. Inside City Limits
24/2004 24/2004	death with the Maryland ms 23a or 28a-f show r nust be multified at	Director	Md. Worcester 10e. Street and Number 6 Woodduck Drive		n Pines 10f. Zip Code 21811		100	g. Citizen of What Co	1 Yes 2 □ No untry?
5-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. so dother than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Seps 2 1 If Yes, Give Year or Dates:	Ever in U.S. 1	3. Was Decedent of Hif Yes, specify Cub		ecify Yes or No- Rican, etc.)	U.S.A 14. Race - Ame Black, White Specify: W]	rican Indian, e, etc.
8/29 2/29	e filed within 72 hc at Hygiene. I other than "natur vent, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	h+}	ecedent's Usual Occup ive kind of work done e. DO NOT use retire Manufactu	ring Rep	o.	Electro	
William 4905 Maryland	should and Mer s marke umatic	To Be	17. Father's Name (First, Middle, Last) Samuel W. Bumpus 19a. Informant's Name/Relationship (Type, Print)		ailing Address (Street	and Number or Rura	Wilson	City or Town, State, Z	
270-34-	8 2 = 5		Ann S. Bumpus/ Spouse 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of Dis cemetery, c	Noodduck sposition (Name of crematory or other place sbury Cre	сө) m. 3-25	Date 20	s, Md. 21 Dc.Location-City or 1 Salisbury	Town, State
Ball	permit. Pac Department Important: any injury once.		21. Signature of Funeral Service Licensee 23a. Pant Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lire	i the death. Do not ne.	22. Name and Addre U111rich enter the mode of dyir	Funera1			Approximate Interval Between Onset and Death
8760,	eath certificate be executed Washing physician and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as cause.)	a consequence of): Consequence of): Consequence of): Consequence of):	ullation us tha Embo		is		Oliser and Death
.O. Box 68	Attending Physician: The law requires that the death certificar death. r death. ector: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	/	4	23d. Date of delin Month	very Day Year
ords, P	v requires that been signed b should be deta	eted by Pl	Part II. Other significant conditions contributing to death be	ut not resulting in the	e underlying cause giv	ren in Part I.			bably 4, Dunknown
ital Rec	ilcian: The law certificate has E rector, page 2 s	Be Completed	25. Was case referred to medical			26. Place of Death	24a. Was an autopsy performe 1 Yes 2	d? death?	opsy findings available ompletion of cause of
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The lawintin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification; To E	examiner? 1 Yes 2 No Hospital: Inpatie 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 1 Accident (Month, Day		e of 28c. Injur	er: 4 Nursing Hor		ce 6 Other (Speci injury occurred	(h)
Divis	To the Hospital or Attending i within 24 hours after death. To the Funeral Director: After completely filled in by the funer	al Certific	4 Homicide building, etc	c. (Specify) of my knowledge, de	street, factory, office	ne, date and place, a	City or Town, s	se(s) and manner as	stated
	To the Hospital within 24 hours a To the Funeral Completely filled	Medica	(Check only one) 2 Medical Examiner: On the basis of and manner state 29b. Signature and title of Centifier	t examination and/or	29c. Licens	pinion, death occurre	ed at the time, date	and place, and due to Date signed (Month,	to the cause(s)
	+1		30. Name and address of person who completed cause of d	eath (Item 23a) (Tyr	pe, Print) (HWA1 DA	e Ber	- M. Mi	nun24,6	2004
J. [71] (2	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 5 2004 32. degistre	ar's Signature	parli		2,11,12		

	Dies	Tune	Dulin	A in Dia	ale la	1 - 121-1	e lade	F					•••	
1 - For State Registrar	Plea	se Type or State o			Depa	rtmen	t of H		and I	Mental Hy		e 2	_	12158
1. Decedent's Name Marie		e, Last) enson								2. Date of De Month March		ay	Year 2004	3. Time of Death 11:20 P ^M
4a. Facility Name (/ Holy Cro		n, give street and nu pital	ımber)					Location		1	4		nty of Death	
5. Social Security N 578-92-1		6. Sex 1 ☐ M 2 📆 F	7. Age	(In yrs. last i	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di May 18	ay, Yea	920	Cou	place (State or Foreign intry)
Usual Residence of	Decedent													
10a. State Virginia	10b. County Orang			Union										10d. Inside City Limits 1 ☐ Yes 2X No
10e. Street and Nur	mber					10f. Zip	Code				10g. C	itizen	of What Cou	intry?

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other treumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	578-92-1751	□M 200 F	83	Yrs	Months .	Days	Hours	Min.	(Month, Da			Country)
	Usual Residence of Decedent		6.5				<u> </u>		May 18	, 19	20 <u>W</u>	Mashington, DC
	10a. State 10b. County		10c. City	, Town o	r Location							10d. Inside City Limits
by Funeral Director	Virginia Orange		Unic	nvi	lle							1 ☐ Yes 2X No
)ire	10e. Street and Number				10f. Zij	p Code				10g. Cit	tizen of Wh	nat Country?
<u>6</u>	9184 Cedar Hollow	Road			22	2567					USA	
ner	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S	S. 1	13. Was Dece	dent of H	ispanic Or	igin? (Spe	ecify Yes or No Rican, etc.))-		American Indian,
F	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🔀							nicati, etc.)			White, etc.
by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates			1 ☐ Yes	2 <u>x</u> ; No	Specify:				Specify:	White
ted	15. Decedent's Ed (Specify only highest gra	ducation		16a. De	ecedent's Usu Rive kind of wo	al Occup	ation	t of work	ina	16b. K	ind of Busin	ness/Industry
ple	Elementary/Secondary (0-12)	College (1-4or	5+)	lif	e. DO NOT	ise retired	i)	SE OF WORK	ing			
Completed	10			Home	emaker					Ow	n Hom	ie
Be (17. Father's Name (First, Middle, Last))					18. Moth	er's Name	e (First, Middle	, Maiden	Sumame)	
70	Antonio Pedon	e					Ger	trude	e Pe	done		
-	19a. Informant's Name/Relationship (Type, Print)		19b. M	ailing Address	s (Street a	and Numb	er or Rura	al Route Numb	er, City o	or Town, Sta	ate, Zip Code)
	Charles F. Benson	So	n	9184	4 Cedar	Hol	low 1	Road	Union	vill	e.Vir	ginia 22567
	20a. Method of Disposition			ace of Di	sposition (Na.	me of			Date			ity or Town, State
	1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif	_	Mary	/lanc	d Vetei	can's	3	·	1 2007	01	1. 1	234 241 1
	21. Signature of Funeral Service Licer		402300		Cemeter 22. Name ar							am, Maryland
	Vois Stile								Funeral			
	23a. Part1. Enter the disease, or com	plications that cause	d the death								Spri	ng,MD 20901 Approximate
	shock, or heart failure. List only Immediate Cause (Final	one cause on each	line.			,	3,					Interval Between Onset and Death
	disease or condition resulting in death)	a <u>Respira</u>				_						
		Due to (or a		ence of):								
L	Sequentially list conditions, any, leaving to infinediate	b. Pneumon										
lne	cause. Enter Underlying Cause (Disease or injury	Cua to (or a	s a consequi	eries of):								
кап	that initiated events resulting in death) Last	c. Due to (or a		anna af):								
Ü		D09 (0 (0) a	s a consequi	ence or).								
dic		d										
Me	IF FEMALE:	00- 1					100					
lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Fetal	déath	3 □Ectopic p					1	23d. Date o Month	•
pleted by Physician/Medical Examiner	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of dea	ath	5 Other (sp	oecify)					William	ouy rour
F.									20 5:44			
þ	Part II. Dther significant conditions of	ontributing to death	but not resul	iting in th	e underlying o	ause give	en in Part i	•				ute to the cause of death?
ted	<u>Dementia</u>								1 🗆	Yes 21	∐No 3[Probably 4 DUnknown
ple									24a. Was		24b. Wei	re autopsy findings available or to completion of cause of
Com									perfo	rmed?	dea	th? Yes 2 🖸 No
Be C	25. Was case referred to medical						26. Place	of Death	Check on		, .	103 202110
0	examiner? 1 ☐ Yes 2 ☆ No	Hospital:	ient 2 ☐ E	R/Outpa	tient 3 D	Othe	ar:		me 5□Resi		6 □Other /	(Specify)
n: T	27. Manner of Death	28a. Date of In	ury :	28b. Tim		28c. Injury	at	-	28d. Describe I			
atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(<i>Month, D</i> i	ay 10ai)	Inju	M	Work	(/ Yes 2□	No				
ific	3 ☐ Suicide 6 ☐ Could not b	286. Flace Of II			street, factor	y, office		1				or Rural Route Number,
ert	4 Homicide	building, e	tc. (Specify)						City or To	vn, State)	
a C	29a. Certifier 1 ☑ Certifying Ph	ysician: To the bes	t of my know	rledge, de	eath occurred	at the tim	ne. date an	d place, a	and due to the	cause(s)	and manne	er as stated
edical Certification:	(Check only 2 Medical Examone)	niner: On the basis and manners	of examination	on and/o	r investigation	, in my op	oinion, dea	th occurre	ed at the time,	date and	place, and	due to the cause(s)
Me	29b. Signature and title of certifler	MANAC	20	13	290	c. License	number			29d. Dat	e signed (A	Month, Day, Year)
		9	-> (4			0.1					2004
	30. Name and address of person o	coulty loted source of	death (Ita-	22a\ (T) 454	121			Marc	h 26,	2004
	OU. HARING AND AUDITOSS OF PRISON	DO DIEGO CAUSE OF	again (Bail)	(۱۷) دعما	pe, ruill)							

State

Registrar

Yeheyis Negussie, M.D.

MAR 3 0 2004

31. Date filed (Month, Day, Year)

porks

32. Registrar's Signature

1111 Spring Street #214 Silver Spring, Maryland 20910

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	For	State of Mary		•		Mental Hy	giene	200	1 1010
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er	4a. Facility Name (If not institution, given Memorial Ho			_	ton	tn		albot	un
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	Usual Residence of Decedent								T
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Tol	BENJAMIN F. BRIT	TINGHAM SR.			DELTA	GORDY			
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	BARBARA A. BRITTI			759 RUMSE	Y DRIVE T				
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3 Time of Death Day **Physician** A.M. April 2004 4:15 Herbert Martin Bloom /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Frederick <u>16 Fairview Avenue</u> If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 XM 2 ☐ F 2, 1917 Maryland Director 216-09-5269 86 Nov. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f ahow the Medical Examiner must be notified at Maryland | Frederick X□Yes 2□No Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 Fairview Avenue 21701 U.S.A. Itema 23a by Funeral Pages 1 and 2 should be filed within 72 hours after death anen of Health and Mental Hyglene.
ant: if item 27 Is marked other than 'natural', or Itema 23.
ury or other fraumatic avent, it a Wedies Earth ar man 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. N☐Yes 2☐No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 TNo Specify: Specify 3√ Widowed 4 Divorced WWII White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer U.S.: Government Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Herbert F. Bloom Katharine E. Bloecher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John M. Bloom (Son) 8512 Rehobeth Court, Vienna, Virginia 22182 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Lorraine Park Cemetery 4/9/04 * 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Robert E. Dailey & Son 21. Signature of Funeral Service 1201 N. Market St. Frederick, MD Approximate Interval Between Onset and Death year 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure **Physician** /Medical Due to (or as a consequence of): 1 year Examiner Myocardial Ischemia and Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner 15 years Coronary Artery Disease and Aortic Stenosis or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. attending physician use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4☐Pregnant at time of death 5 Other (specify) P.0. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 90 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only onel 29c. License number 29b. Signature and title of certifi 29d. Date signed (Month, Dey, Year) arn Keasson M. April 6, 2004 VA0101037386 15+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arn H. Eliasson, MD Walter Reed Army Medical Center, Washington, D.C. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Dockers APR 0 8 2004 Registrar

			For State Registrar	State of Ma	aryland / Depa Ce	artment of			giene Reg. No. 2	201	
	Physic		Decedent's Name (First, Middle, Last Jan	Marie				2. Date of De Month March	ath Day	Year 2004	3. Time of Deluh
×	/Medi Examir		4a. Facility Name (If not institution, give Frederick Memoria	street and number)			or Location of De		4c. Count	y of Death	12111
	Funeral Director		5. Social Security Number 6. S		9 (In yrs. last birthday) 39 Yrs.	If Under 1 Year Months Day	r If Under 24 H		th y, Year)		lace (State or Foreign
	within 72 hours after death with the Maryland she. then "neturel; or Items 23a or 28e-f show the Medical Examiner must be notified at	Director	10a. State 10b. County MD Frede	rick	10c. City, Town or Lo	.11e			10g. Citizen of		0d. Inside City Limits 1 ☐ Yes 2 ☒ No
	leath with ns 23a or must be r	Funerai Dir	822 Knoxville Roa	d 12. Was Decedent	Ever in U.S. 13.		1758	(Specify Yes or No	U	ISA ce - Americ	
9000	ours after d rei', or Iten Examiner	b	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ XI If Yes, Give Year or Dates:	10	If Yes, specify Cu 1 ☐ Yes 2 🛣 N		(Specify Yes or No erto Rican, etc.)	Speci	ck, White,	etc.
21215-0036	d within 72 h jiene. r then "netu r te Medica	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give		upation e during most of w ed) y Technic		Loudou Leesbu	n Hos	pital Cente
Maryland 2	12 should be filed within h and Mental Hygiene. 7 is merked other then " treumatic event, the Mer	To Be C	17. Father's Name (First, Middle, Last) Robert Melvin Ta	y1or			Sara I	ame (First, Middle, Frances A	Maiden Suma. 11en	me)	
	ges 1 and 2 should be filed within 72 hours after death with the Marylar tof Health and Mental Hygiene. If Item 27 is marked other then "neturel", or Items 23s or 28e-f show or other treumatic event. The Medical Examiner must be notified at		James D. Bowden, 20a. Method of Disposition	Husband	822 K	noxvill	e Road, H	Rural Route Numbe Cnoxville Date		758	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is eny injury or other tre once.		1 ☐ Surial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify 21. Signate of Funeral Service Licen	99 h/11	St. Mark	's Ceme	tery 4/5 ress of Facility Williams	Funeral			
	Priysician		Dalbara A. W1 23a. Part1. Enter the disease, or com, shock, or heert failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line a	the death. Do not ent	er the mode of dy	ring, such as cardi			<u>MD</u> 2	1716 Approximate Interval Between Onset and Death
8760,	Medical Examiner bhysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): ALL PLAT: a consequence of): a consequence of):	uetive	lung a	ris disease			
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the buriat-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnan	су			ite of deliver	y Day Year
	quires that an signed b uld be deta	by	Part II. Other significant conditions of	malletus		nderlying cause g	iven in Part I.	23e. Did to			e cause of death?
Il Records,	: The law requicate has been a	Completed	Obesity					24a. Was autop perfor 1 □ Yes	med?	prior to com	sy findings available apletion of cause of
on of Vital	ding Physicien: The la h. Atter this certificate has funeral director, page 2	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 Inpatie	y 28b. Time of	28c. inju	ther: 4 🗆 Nursing	eath Check onl of Home 5 Resided Rescribe h	ence 6 Oth	ner <i>(Specify)</i> red	
Division	or Atten after deat Director; in by the	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined		iry - At home, farm, str c. (Specify)			28f. Location (S City or Tow	itreet and Numb n, State)	oer or Rural	Route Number,
	To the Hospitel within 24 hours a To the Funerel completely filled	Medicai C	29a. Certifier 1 ☐ Certifying Ph (Check only one) 1 ☐ Medicel Exem	ysician: To the best on the basis of and manner sta	of my knowledge, death examination and/or invited.	occurred at the restigation, in my	ime, date and place opinion, death occ	ce, and due to the courred at the time, co	ause(s) and madate and place,	anner as sta and due to	ited. the cause(s)
)	Mithi To t	M	29b. Signature and title of certifier	Hogue M	nD -	29c. Licer	00546	36	29d. Date signe	d (Month, D	ay, Year)
	10		30. Name and address of person who of STED HAQUSE	700 Mo.	path (Item 23a) (Type, NTCLAIRE u's Signature	Print) AVE,	FREDE	RICK M	1D. Z	170	ĺ
	Sta Registi	A. 30	31. Date filed (Month, Day, Year) APR 0 5	32. Registra	r's Signature	tous					

Beau M.	Black
04-2316	
TATE C	F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1. State Unpend Item#23a,27,28a-f,Per ME,G830-64777.0468 of Death

Beg. No. 6

Beg. No. 6 Reg. No. 2 Un L 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year Beau Michael Black 3:01_P^M /Medical April 4, 2004 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Sinai Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 12/05/1980 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 220-13-8694 1 SM 2 F Mary Land Yrs. Director 23 Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 3604 Dewberry Circle 238 21157 USA Funeral iteme ! 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after of Hygiene.
Hygiene.
Ither than "natural", or item Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 2 Specify: White 3 Widowed 4 Divorced natural', Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Control Technician 12 should be filed w h and Mental Hygier 7 Is marked other th Sheet Metal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Adam Black Melanie Hudacik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Item 27 Adam Black/Father 3604 Dewberry Cr., westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Inc.04/06/2004 Hampstead, Maryland 21. Signature of Funeral Service Licensee 22. Prittsdfuneral Home & Chapel, P.A. 412 Washington Rd., Westminster, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Narcotic Intoxication **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of it all y that initiated events Examiner Due to (or as a consequence of): sicien and burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, The law requires that the death certificate be Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 3 ☐ Probably 4 ∰Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 2 9 s 2 No 24a. Was an autopsy performed? 1 Yes 2 No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Ch. ck only one) Hospital: 1 | Inpatient | 2 | R/Outpatient | 3 | DOA | Other: 4 | Nursing Home | 5 | Residence | 6 | Other (Specify) Certification: To 1 XYes 2 □ No After thi 28a. Date of Injury 1011111001111, Oay Year) 4/4/04 2:25 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending in 24 hours after death, the Funerel Director: A investigation 2:25 1 ☐ Yes 2 X No unknown 2 ☐ Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 3316 Menlo Drive, Baltimore,MD found in residence Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp wit in 24 hos To the Fune completely fi Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WIN c/ mus O.C.M.E. April 5, 2004 30. Name and address of person who complete can se of death (Item 23a) (Type, Print) 11000 ST 11 = 4 111 Pens Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

APR 13 2004

DHMH 17 Rev 1/2001

ORIGINAL

		1 - For State Registrar	State of Maryla	nd / Depa		lealth and		•	12163	
Physic /Medi	cal	Decedent's Name (First, Middle, Last,	Laine Briggs		di Ch T		1	Day Year 200	4 0700 AM	
Exami	ner	4a. Facility Name (If not institution, give SINAL HOSPITAL OF 5. Social Security Number 6. Sec	BALTIMORE	s. last birthday)	BALTIN If Under 1 Year	or Location of Dea MPRE CI If Under 24 Hrs	5. 8. Date of Birth	4c. County of Dea	rthplace (State or Foreigr	
Director		215-78-8685 Usual Residence of Decedent 10a. State 10b. County		Yrs.	Months Days	Hours Min	April 25,		Maryland	
the Maryle 28a-f sho	Director	Maryland Carrol		Westmi			100	Citizen of What C	10d. Inside City Limits 1X Yes 2 No	
BAITIMOFE, IMARYIANG Z1Z13-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-7 show many injury or other traumatic event, the Modical Exercit entitled by ODICE.	by Funeral	42 North Court S 11. Marital Status 1 Nover Married 2 Married 3 Widowed 4 Divorced	Street 12. Was Decedent Ever in I Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		21	157 dispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	USA 14. Race - Am Black, Whi	erican Indian,	
Z I Z I S-UUSO d within 72 hours aff giene. ar than "natural", or if the Medical Even.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done OO NOT use retired Retireme	during most of wo d)	rrking	o. Kind of Business Rowe P	/Industry	
Maryland ZIZI td 2 should be filed within th and Mental Hygiene 27 Is marked other than traumatic evant, the Maryland	To Be Co	17. Father's Name (First, Middle, Last) John Edward Brid	ggs .			18. Mother's Na Joyce	me (First, Middle, Mail Elizabeth	den Sumame) Linde		
ore, Mar ss 1 and 2 sh of Health and litem 27 Is m r other treum		Joyce E. Dickhoff, 20a. Method of Disposition	'Mother	531 H		, Westmi	nster, MD	te Number, City or Town, State, Zip Code) 21157 20c. Location - City or Town, State		
Dallimore, permit. Pages 1 a Department of Her Important: If item any injury or othe		1 ☐ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Ca	rroll (remation	Inc04/0		mpstead,	Maryland	
And the private state of the p	Ical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any serious (Disease or injury that initiated events resulting in death) Last	A AORTIC Due to (or as a conse	DISSECT quence of): IVE TIS			c or respiratory arrest.		Approximate Interval Between Onset and Death 12 Hours 5	
the death certificate y the attending phy ched for use as the	Physiclan/Medlc	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	3c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	ivery Day Year	
quires that en signed by	by	Part II. Other significant conditions con		sulting in the ur	derlying cause give	en in Part I.			the cause of death?	
The law requires t cate has been signe page 2 should be contracted.	Completed	PULMONARY ED MYOCARDIAL ISC					24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of	
Mtending Physician: The death. ctor: After this certificate y the funeral director, pag	atlon: To Be	25. Was case referred to medical examiner? 1	ath (Check only one) tome 5 Residence 28d. Describe how in	6	cify)					
or fiter	al Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specialization): To the best of my kn	ify)		na date and ala-	28f. Location (Street City or Town, St	ate)		
1	Medical	29b. Signature and title of certifier	and manner stated.	ation and/or inv	estigation, in my or	pinion, death occu a number	rred at the time, date a	and place, and due Date signed (Monti	to the cause(s)	
Cen		7 PLEW W. (30. Name and address of person who co PETER W. CHo, M.	mpleted cause of death (Ite					RIL 1, 20	-	
Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature		cc) PAUL	Isaal Library	THE POLICE		

			For 1_ State	State of M			ent of H	lealth and	-	/giene		
	_		Registrar	-41		Cerunca	ale of	Dealli	2. Date of D	Reg. No.	200	4 12 164
	Physici	an	1. Decedent's Name (First, Middle, La	,					Month	Day	Year	3. Time of Death
	/Medic	cal	Lawrence M. Bro		-)	4.0	· *	al andian of Dark	03	26	04 County of Dea	10:20 p ^M
100	Examin	ier	4a. Facility Name (If not institution, giv Southern Marylan				linto:	or Location of Deat	n		ince Ge	
			5. Social Security Number 6. S		⊥ Age (In yrs. last bi		ider 1 Year	If Under 24 Hrs	. 8 Date of B			
DOPM	Funeral Director			1⊠M 2□F	81	Yrs. Mont		Hours Min.		2/192	3 So	rthplece (State or Foreign ountry) uth Carolina
0	land		10a. State 10b. County		10c. City, Tow	n or Location						10d. Inside City Limits
0	Mary f sh	tor	MD Prince 0	George's		Suit	land					1x Yes 2 No
CX	the routing	Director	10e. Street and Number			10f.	Zip Code			10g. Citiz	zen of What C	ountry?
	3a o	Ē	3402 Parkway Ter	race #2		1	2074	6		Uni	ted Sta	ates
X	deatl	Funerai	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	13. Was De	ecedent of H	dispanic Origin? (S an, Mexican, Puer	pecify Yes or N	0- 1	14. Race - Am Black, Whi	erican Indian,
Ro	after or the	Ē	1 ☐ Never Married 2 ☐ Married	1 Yes 2			s 2⊠ No		to rican, etc.)		Specify: B	
5-0036	raf,	d by	3X Widowed 4 □ Divorced	Year or Dates	:	10.00	3 223 140	Specify.			Specily: D	
5-0	72 h 'natu	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a	. Decedent's U (Give kind of	sual Occup work done	nation during most of world)	rking	16b. Kir	nd of Business	:/Industry
72	Aithin han '	mpi	Elementary/Secondary (0-12)	College (1-4o	r 5+)			d)		D.		
2	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examinat must be notified at		7th 17. Father's Name (First, Middle, Last	1		Coo	K	18. Mother's Nar	ma (First Middle		rivate	
$\frac{1}{2}$	€ d	Be	James Brown	/				Hattie		ord	Sumame)	
3 6	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the Ms	10	19a. Informant's Name/Relationship (Type Print)	104	Mailine Adde	roce /Stroot	and Number or Ru			Tour Ctata	Zin Codo)
, Ma	s 1 and 2 should f Health and Men item 27 Is marke other treumatic		Catrina Bright/ C		nter 34	402 Par	kway	Terrace	#2 Sui	tland	, MD 20	0746
ore	of H of H or oth		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □	Removal from State		f Disposition (i			Date		cation - City or	
I, VE	Pages ment of ent: If it		`4 □Donation 5 □ Other (Special		Maryla	and Vet					tenham	
Saltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tre 2002.		21. Signature of Funeral Service Lice	a PC				oss of Facility J.				
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	ed the death. Do	not enter the n	node of dyin	ng, such as cardiad	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	C	oncie	Ctivio	> i	10021	- fa	1/11	C.	Onset and Death
	/Medical		resulting in death)	Due to (or a	is a consequence	of):		Corc	100	TOUT		
	Examiner		Controlly Cat and House	. ((roong-	m F	784e	m d	15-ear	re		
	п #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a consequence	of c						
	e be executed rsician and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
760,	te be exe ysician a ne burial-		resulting in death) cast	Due to (or a	is a consequence	of):						
376	~ ~ ~	lical		d								
(88	The law requires that the death certificate ate has been signed by the attending physinage 2 should be detached for use as the	Physician/Medi	IF FEMALE:									
S S	ath ce ttend or use	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		c pregnancy	1		2	3d. Date of de Month	livery Day Year
ەرخ ق	e deg	Sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of death	5 🗌 Other	(specify)					24)
~ Z.	d by tetach	Phy	Part II. Other significant conditions		hut not consider:	a tha cardachda		un in Park I	220 Did	tobassa us	no gostalbuto t	o the cause of death?
<u>v</u> €	w requires that the deben signed by the should be detached	þ	Part II. Other significant conditions (contributing to death	but not resulting i	n the underlyin	ig cause giv	en in Part I.		Yes 2		robably 4 DUnknown
ecords	requi	Completed								183 2	1140 21	- DOTATION I
2	law lasb e2sl	npie							24a. Wa auto	psy	prior to	utopsy findings available completion of cause of
2/2	The page	S							1 ☐ Yes	ormed? 2 No	death? 1 ☐ Yes	2 No
/ita	cian: ertific actor,	Be	25. Was case referred to medical examiner?	112-1	·····			26. Place of Dea	ath (Check only	оле)		
∩ / L of Vital	hysi this c	2	1 □ Yes 2 XNo	Hospital: 1 Anpai			DOA Oth	4 Li Nursing F	lome 5 Res			icify)
0 4	Attending Physician: r death. octor: After this certific: by the funeral director,	Certification:	27. Manner of Death ↑ ANatural 5 ☐ Pending	28a. Date of In (Month, D	Jury Year) 28b.	Time of Injury	28c. Injur Wor		28d. Describe	how injury	occurred	
Sion	tend leath tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be			М		Yes 2 □No	001 1 1	(2)		
<u>₹.</u> 5	or At fter d lirect n by	THE STATE OF	4 Homicide determined	280. Place of I	njury - At home, fa etc. <i>(Specify)</i>	arm, street, fac	tory, office			(Street and wn, State)		ural Route Number,
OTO	urs a											
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	nysician: To the bes miner: On the basis and manners	of examination ar	e, death occurr nd/or investigat	tion, in my o	me, date and place opinion, death occu	e, and due to the irred at the time	cause(s) a , date and	and manner as place, and due	s stated. s to the cause(s)
	Vithin To th comp	M	29b. Signature and title of certifier	1	-		29c. Licens			29d. Date	signed (Mont	h, Day, Year)
				Polo			D4	6478		3.3	30.6	4
c. D	(2)		30. Name and address of person who	completed cause of	death (Item 23a)	(Type, Print)						,
4			sureth A.Pa	tel un	7501	SUZ	Srat	to Rel	clint	200	mp à	20735
	Sta		31. Date filed (Month, Day, Year)		strar's Signature	1		-	-			
	Regist	rar	APR 0 1 2004	Man	. K /	Topal 1						

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State of Maryland / Department of I	Health and Mental Hygiene 🗸	AAI

12165 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2004 28 4:35 A Gloria Brooks March /Medical 4c. County of Death 4b City Town or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Silver Spring

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Forest Glen Skilled Nursing Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F Yrs. 48 Virginia Director 578-74-2018 Usual Residence of Decedent 10d. Inside City Limits r 28a-f show 10a. State 10b. County 10c. City, Town or Location TX☐ Yes 2 ☐ No Silver Spring Maryland Montgomery Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or the Medical Examiner must be 2700 Barker St. 20910 United States death i Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1X Never Married 2 ☐ Married jo. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: **Black** þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 8th Unemployed nd 2 should be filed that and Mental Hygie 27 is marked other traumatic event, III other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important; if item 27 is marked of any injury or other traumatic every 20x8. Harrison Leo Brooks Ozzie Lea Ingram 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie B. Mays - Sister 723 A Melon Terrace, Philadelphia, PA 19123 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial Cem. 4/2/2004 * 4 ☐Donation 5 ☐ Other (Specify) Suitland, MD 21. Signal re of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home Terror 4001 Benning Rd., N.E. Wash., DC 20019 MURO 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Liver Cirrohsis Physician /Medical Due to (or as a consequence of): Examiner Hepatitis Sequentially list conditions, if any, leading to immediate Enter Inderlying Cause (Disease or injury that in its and in the control of the co Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the al 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Human Immune Deficiency Syndrome peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy page 2 2 (No certificate 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide o the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and March, 30, 504 Willow ompleted cause of death (Item 23a) (Type, Print) 30. Name and address of person w Arasto Yazdani, M.D. 9801 Georgia Ave., #3-41, Silver Spring, MD 20902 31. Date filed (Month, Day, Year, 32. Registrar's Signature State APR 0 1 2004 Registra

			For State Registrar	State of Maryland		artment of I			Reg. No. 2001	+ 12166
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Willard George	Bull				2. Date of De Month March	Day Year 23, 2004	3. Time of Death 5:30 a M
	Examir		4a. Facility Name (If not institution, give s 9900 Dale Drive			Upper N	or Location of Deat		4c. County of Deal	George
1	Funeral Director		5. Social Security Number 221–28–1654 Usuel Residence of Decedent	7. Age (In yrs. la	Yrs.	If Under 1 Year Months Days			y, Year) 1945 Vir	hplace (State or Foreign puntry) ginia
	Maryland	tor	10a. State 10b. County Maryland Prince Ge		Town or Lo					10d. Inside City Limits 1
	th with the 23a or 28a	ai Direc	10e. Street and Number 9900 Dale Drive			10f. Zip Code 20772			10g. Citizen of What Co United Stat	
036	iges 1 and 2 should be tiled within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 X Marned 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ⊕Yes 2 □ No5 / 5 / If Yes, Give 57 37 6 Year or Dates:	1 1	Was Decedent of f Yes, specify Cut I ☐ Yes 2 ☐ No	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
Maryland 21215-0036	e filed within 72 ho al Hygiene. I other than "natur vent, ILe Medical	ompieted	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	DO NOT use retire	during most of wo	rking	16b. Kind of Business/	Industry
yland 2	should be filed ind Mental Hyg s marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) Willie George				18. Mother's Nar Daisy	me (First, Middle, Bull	Maiden Sumame)	
	and 2 sho lealth and i m 27 is mu		19a. Informant's Name/Relationship (Ty) Frances Bull / Wif	e	9900	Dale Dr	ive Upper	Marlbon	or, City or Town, State, 200, Md. 207	72
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	Mary	land \	sition (Name of natory or other pla Veteran	Cem. 3/3	Date 31/04	20c. Location - City or Cheltenham	
Ball	permit Depart import eny in		21. Signature of Funeral Service License	w	5.	538 Mar1		Forest	ville,Md. 2	
J. T.	Physician /Medical Examiner		23a. Part Enter the disease, or combine shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Lung Cancer Due to (or as a consequ		er the mode or dy	ng, such as cardia	c or respiratory ai	1951,	Approximate Interval Between Onset and Death
8760,	ate be executed sysician and he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter funderlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ						
O. Box 6	the death certifi y the attending iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnand Other (specify)	y		23d. Date of dei Month	ivery Day Year
<u>a</u>	signed be de	by	Part II. Other significant conditions cor	tributing to death but not resu	lting in the ur	nderlying cause g	ven in Part I.		obacco use contribute to	the cause of death?
al Records,		Completed						24a. Was autop perio 1 🗆 Yes	an 24b. Were au prior to comed? death? 2X No 1 Yes	stopsy findings available completion of cause of 2 No
ion of Vital	Attending Physician: "r death. ector: After this certifica by the funeral director, p	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	T	ER/Outpatien 28b. Time of Injury	28c. Inju	her: 4 Nursing H		dence 6 □Other (Spec now injury occurred	sify)
Division	\$ # 15 E	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and Number or Ru vn. State)	ıral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medicel Examination)	sician: To the best of my knowner: On the basis of examinati and manner stated.	vledge, death on and/or inv	vestigation, in my	opinion, death occu	urred at the time,	date and place, and due	to the cause(s)
	2 mg 2 mg	1	29b. Signature and title of certifier	. welly	J	Dá	se number 23743		29d. Date signed (Month	* '
K	9/16		30. Name and address of person who come address of person who come address of person who come and address of person who come address of	z. M.D. 75	256	STERN.	way C	tr. Br.	Greens	5, 2004 ett, MD 2019
	Sta Regist		MAR 2 9 2004	32. Registrar's Signat	Grand	E .	0			

		For State Registrar	State of Ivia		partment of He e <i>rtificate of D</i> e			g. No. 2	004	1216
Physicia		1. Decedent's Name (First, Middle, Last Walter Joseph					2. Date of Death Month March 2	Day	Year 104	3. Time of Death 6:25am M
/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or Lo	ocation of Death			y of Deeth	072344
		Southern Maryland	Hospital		Clinton			Princ		rge's
Funeral Director		3//-12-2003	X 7. Age	(In yrs. last birthda 92 Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 29,		9. Birthp Court Mary	lece (State or Foreign try) 1and
and		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				1	0d. Inside City Limits
f sho	ō	Maryland Prince Ge	orge's	Fort Was	hington					1 Yes 2 No
r 28a-	Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of	What Coun	try?
72 nours after death with free Maryland naturel', or Itema 23a or 28a-f show Jical Examinet must be multified at		9007 Pinehurst	Drive		2074	44		Unite	ed Sta	tes
ema er m	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13	. Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Sp Mexican, Puerto	pecify Yes or No-		ce - Americ	
should be manyang the Medical Examinet must be notified at imatic event, the Medical Examinet must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Wildowed 4 ☐ Divorced	1 □ Yes 2 X No If Yes, Give Year or Dates:			Specify:		Speci	4	lack
natur	Completed	15. Decedent's Edi (Specify only highest grad		(Gir	edent's Usual Occupation	on ring most of wor	king 1	6b. Kind of 6	Business/Inc	dustry
Hygiene. ther than "	d L	Elementary/Secondary (0·12)	College (1-4or 5-	+)	DO NOT use retired) ostal Worke			Feder	al Co	vernment
Hygin other ent,		17. Father's Name (First, Middle, Last)					e (First, Middle, M			verment.
Mental arked o	To Be	Joseph Brow	m			Helen M	ary Eliza	abeth	Johns	on
f Health and Men item 27 is marke other traumatic	5	19a. Informant's Name/Relationship (T	ype, Print)	19b. Ma	iling Address (Street and	d Number or Ru	ral Route Number,	City or Town	, State, Zip	Code)
Health tem 27 other tra		Donald W. Greenfie	ld/Nephew		Ritchboro	RD. Fo	restville	_	2074	
0		20a. Method of Disposition 1	Removal from State	20b. Place of Dis cemetery, ci	position (Name of ematory or other place)	į	Date 2	Oc. Location	· City or To	wn, State
tment tant: jury	١.,	* 4 ☐ Donation 5 ☐ Other (Specify,)		Heaven Cem		30, 2004	Silve:	: Spri	ng, MD
Department Important: If any injury o		21. Signature of Funeral Service Licens	See Will	70 (/// E	^{22. Name and Address} lexander S Forestville	. Pope 1	Tuneral H	omes/	538 M	arlboro P
nysician Medical Medical transit s the prival-transit	edicai Examiner	shock, or heardfailure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Demeni Due to (or as a b. Due to (or as a c.						u	Interval Between Onset and Death nknown
ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 24 Pregnant at the 19 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)				ate of delive	ry Day Year
500	by	Part II. Other significant conditions co	entributing to death bu	t not resulting in the	underlying cause given	in Part I.		acco use cor		e cause of death?
has been si ge 2 should b	Completed	Hematuria					24a. Was an autopsy perform		prior to cor death?	osy findings available
certificate rector, pag	ပိ	25. Was case referred to medical			2	E Place of Dea	1 ☐ Yes 2		1 🗆 Yes	2∐ No
is certificate hi	To B	examiner?	Hospital: 1 Inpatier	nt 2 ER/Outpati			ome 5 Resider		her (Specifi	•)
h. Alter th tuneral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	y Year) 28b. Time Injury	of 28c. Injury a Work?		28d. Describe how			,
iter deat Sirector: in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined			street, factory, office		28f. Location (Str. City or Town,		ber or Rura	Route Number,
within 24 hours after To the Funerel Discompletely filled in	Medical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Example 1	(sician:)o the best of iner: On the basis of and manner stat	examination and/or	ath occurred at the time, investigation, in my opin	date and place, ion, death occur	and due to the ca red at the time, da	use(s) and m te and place	anner as st and due to	ated. the cause(s)
within 24 h To the Fun completely	Me	29b. Signature and title of certifier	1	,/	29c. License n	umber	29	d. Date sign	ed (Month, I	Day, Year)
S + 5		14001	TOM	Ulm	504	104	\wedge	Jan	1,25	,04
(10)		30. Name and address of person who d			e, Print)	<u> </u>				
						11 011	C	MI		000
		Arastoo Yazdani,	M.D. 9801	Georgia A	ve., Ste. 3	341, 511	ver spri	ng, mu	. 20	902

/0/0 DHMH 17 Rev 1/2001

		For State Registrar		epartment of Health and Dertificate of Death	Reg.	No. 2004 1216
Physicia /Medic	al	Decedent's Name (First, Middle, Last, GLADYS 4a. Facility Name (If not institution, give	BRASTE	D 4b. City, Town, or Location of De		26 2004 4:30 P
Examin Funeral		3801 Atlantic Av 5. Social Security Number 6. Secur	/e. Apt. 104 7. Age (In yrs. last binth	Ocean City day) If Under 1 Year If Under 24 H Months Days Hours M	rs. 8. Date of Birth	Worcester
Director		229-26-7874 1L Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	s.	Feb. 9,	1926 Virginia
or 28a-f st	Director	MD Worcest		an City 10f. Zip Code	10g.	1 □X es 2 □ f
i Health and Menial Hygiene. Item 27 ie marked other than "naturel", or Items 23e or 28a-f show other traumatic event, the Medical Evaniner must be notified at	Compieted by Funeral Director	3801 Atlanti 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	C Ave. Apt. 1(12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 ☑ No Specify:	(Specify Yes or No- erto Rican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: White
ane. than "natur or Medical	mpieted	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 1 2	cation 16a. Completed) (16a. Completed) (16a. Completed) (16a. Completed)	ecedent's Usual Occupation Give kind of work done during most of v fe. DO NOT use retired) Homemaker	vorking	c. Kind of Business/Industry
and Mental Hygiene. ie marked other the manatic event, the Manatic eve	To Be Co	17. Father's Name (First, Middle, Last) Ralph Croson		18. Mother's N	lame <i>(First, Middle, Mai</i> ssa Martir	
Health and M em 27 ie mar ther traumat		19a. Informant's Name/Relationship (Ty James Fain / Sc	on 30	Mailing Address (Street and Number or 4 #3 33rd St.	Rural Route Number, Ci	
Department of Health Important: If Item 27 eny injury or other trong once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	Lakemo	nt Mem. Gardens	30- 2004 Da Beall Fun	a Location - City or Town, State A vidson ville, Mi A eral Home
/sicia	ical Examiner	shock, or heart failure. List only of limediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	0-1			Interval Between Onset and Death OM Guor
by the attending phystached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
been signed by should be deta		Part II. Other significant conditions cor	ntributing to death but not resulting in t	ne underlying cause given in Part I.		co use contribute to the cause of death?
page 2 sho	Completed by				24a. Was an autopsy performed 1 ☐ Yes 24 ☐	
r this certificate and director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death	lospital: 1 Inpatient 2 ER/Outp 28a. Date of Injury (Month, Day Yeer) 28b. Tin	atient 3 DOA Other: 4 Nursing	eath (Check only one) Home 5 Residence 28d. Describe how in	
after death. Director: After thi I in by the funeral of	Certification	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	(Month, Day Yeer) Inju 28e. Place of Injury - At home, farm building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street City or Town, St	t and Number or Rural Route Number, late)
within 24 hours after deat To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one) 12 Certifying Physical Medicel Examination	sicien: To the best of my knowledge, oner: On the basis of examination and/of and manner stated.	death occurred at the time, date and plate investigation, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
within To the	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
0		30. Name and address of person who co	mpleted cause of death (Item 23a) (Ty	(Pecutional R)	Serlin no	0 01611

			1 - For State Registrar	State of M	Marylar	nd / Depa	artmer rtificat	t of H	ealth a Death	nd M	ental Hy	/giene Reg. No	/ 11:) 4	12	169
П	Physic	an	1. Decedent's Name (First, Middle, Charles			n 1		-			2. Date of De Month	Day	/ Ye	ear	3. Time of I	
345	/Medi	cal	4a. Facility Name (If not institution,	M.		вая	er,		I nanting of		March	25,	2004		1:27	′P. ^M
	Examir	ner	10875 Hammond		91 /		4b. City,		Location of Laure			4c. County of Death Howard				
	Funeral	-		. Sex 7. /	Age (In yrs.	last birthday)	If Under		If Under 2		8. Date of Bir (Month, Da			Birthpla	ice (State or	Foreign
	Director		218-30-2597	1 XM 2□ F	68	Yrs.	Months	Days	Hours	Min.	June4	ay, Year) • 1935		Countr lary	y)	
	and		Usual Residence of Decedent 10a. State 10b. County		10c Cit	ty, Town or Lo	cation							_	d. Inside City	. I fanis
	Maryl 1 sho	ŏ	Maryland Howard			Laure								100	1 🗆 Yes	
	28e	rect	10e. Street and Number				10f. Zip	Code				10a. Citi	zen of Wha	t Countr		
	th with	a	10875 Hammond D	rive				2	0723			_	Unite		•	
	72 hours after death with the Maryland nature!, or items 23a or 28e-f show dical Examiner must be notified at	Funeral Directo	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U	J.S. 13.	Was Dece			in? (Spec	cify Yes or No Rican, etc.)		14. Race - /	American	n Indian,	
36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ If Yes, Give	XNo		1 🗆 Yes		Specify:	1 06/10 1	tican, etc.,		Specify:	Vhite, et		
8	hour turel	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates	s:							105 16			nite	
5	n na	Completed	(Specify only highest	grade completed)		16a. Deced (Give	kind of wo DO NOT u	rk done d se retired	luring most o	of workin	g	16b. Ki	nd of Busin	ess/Indu	istry	
212	d within giene. or than	mo	Elementary/Secondary (0-12)	College (1-4o	or 5+)	Self						Au	to Bo	dv S	Shon	
pu	be filed within 72 ho ital Hygiene. id other than "natur avent, the Medical	BeC	17. Father's Name (First, Middle, La						18. Mother	s Name	(First, Middle			uy L	пор	
yla	2 should be to and Mental I is marked or raumatic ave	70	Charles M. Baker	r, Sr.							Walker					
Maryland 21215-0036	iit. Pages 1 and 2 should be artment of Health and Menta ortant: If Item 27 is marked injury or other traumatic at		19a. Informant's Name/Relationship Sue E. Baker -wi			19b. Mailir	ng Address	(Street a	nd Number	or Rural	Route Number	er, City o	Town, Star	te, <i>Zip C</i>	ode)	
e,	1 and Health em 27 ther t		20a. Method of Disposition		20h F	Place of Dispo			DITVE	-	ite					
Baltimore,	ages int of it.		1 Burial 2 Cremation 3		. ! 0	cemetery, cren	natory or o	thar place	e)				cation - City			
Ħ	permit. Page Department of Important: If any injury or once.		* 4 □ Donation 5 □ Other (Special Service Lice)		11100	tropoli	Name an	d Addres	s of Eacility	3/20	72004	ATE	xandr.	ıa,	Virgi	nia
Ba	permit. Departn Imports any inju		David V.	Barrowa	at	_ Dc	onald	V. I	Borgwa	rdt	Funera d Belt	l Ho	me, P	.A.	7.0	.=
0	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)		tatic as a conseq	Small uence of):								Ir	oproximate nterval Betwo	een
68760,	death certificate be executed e attending physician and ad for use as the burial-transit	ledical Examiner	cause. Enter Underlying Cause (Disease or injury that inftated events resulting in death) Last	c. Due to (or a	as a conseq	uence of):										
P.O. Box (that the death certil ted by the attending detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ ∀es 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	Ideath 3	Ectopic pro					2	3d. Date of Month	delivery Da		ar
Division of Vital Records, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions Ischemic Cardio	contributing to death myopathy;	chron	ulting in the un	truct	ause give Live	n in Part I.						cause of dea	
000	has bei	Completed	Pulmonary Disea	se							24a. Was				y findings av	
<u> </u>	The ate h page	E C									autop perfor	rmed?	death	?	letion of cau □ No	ise of
/ita	Physicien: Th r this certificate ral director, pag	Be (25. Was case referred to medical examiner?						26. Place of	f Death (Check only o	^	- 44			
<u></u>	Physic this or al dire	၉	1 ☐ Yes 2 📉 No	Hospital:		ER/Outpatient			4 🗆 Mul Si	ing Home	e 5 X Resid	lence 6	□Other (S	pecify)		
nc	ding F	lon	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of In (Month, D	jury Jay Year)	28b. Time of Injury		Bc. Injury Work			d. Describe h	ow injury	occurred			
<u>isi</u>	Attending r death. sctor: After by the fune	icat	2 Accident investigati 3 Suicide 6 Could not	be 29a Blace of In	niuny - At ho	ome form stee	M factor		es 2□No		t Location (C	traat and	Alumbasa	0		
<u>></u>	tel or A rs after el Direc ed in by	Certification:	4 ☐ Homicide determine	d 286. Place of it building, 6	etc. (Specify	ome, tarm, stre	eet, ractory	, office		28	f. Location (S City or Tow	m, State)	Number or	Hurai H	oute Numbe	ir,
	To the Hospitel or Attending Physicien: within 24 hours after death of the Funerel Director. After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Example 1	Physician: To the bes aminer: On the basis and manner s	or examinar	wledge, death tion and/or inv	occurred a estigation,	at the time in my opi	, date and p nion, death	occurred	d due to the o	cause(s) a date and	and manner place, and c	as state	ed. e cause(s)	
	To the within ?	Σ	29b. Signature and title of certifier	Han			29c.	License					signed (Mo	-		
	(0		100					D22					h 26,	200)4	
_	U		30. Name and address of person who G.M. Din, M.D.	6510 Keni	death (Item 1wort)	h Avenu	e Riv	verda	ale, M	aryl	and 20	737				
4)-	Sta Registr		31. Date filed (Month, Day, Year)		trar's Signal	ture 4	de	an Ka	1							

			For State Registrer	State of Mar	ryland / Dep		Health and	Mental Hy	giene 2004	12170		
	*:		1. Decedent's Name (First, Middle, Last)				2. Date of De	ath	3. Time of Death		
	Physici		Jean Marguerite	Becht				March	27 ^{Day} 2004	2:50 A M		
}	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of De	ath	4c. County of Death)		
			Bedford Court Nur	sing Home		Silver	Spring		Montgomer	у		
	Funeral		Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Year Months Day			th 9. Birth	place (State or Foreign intry)		
	Director		5//-36-5/80]M 2⊠F	83 Yrs.	Wioritis Day	3 110013 1411	Feb. 22	, 1921 III	inois		
	and *		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Town or Lo	ocation				10d. Inside City Limits		
	sho	2	,							1 ☐ Yes 2 ☒ No		
	Z8e-f	ecti	Maryland Montgon 10e. Street and Number	nery	Silver				10 - Chin of Mile C-			
	with a or	by Funeral Director	3700 Internation	a 1 Dantas		10f. Zip Code			10g. Citizen of What Cou	intry?		
	eath	eral	11. Marital Status	12. Was Decedent Ev	rer in IIS 13	2090		(Specify Ves or No	USA - 14. Race - Amer	ican Indian		
10	ter d	'n	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔼 No	0.3.	If Yes, specify Cu	ban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	Black, White			
936	urs at	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1☐ Yes 2☒ N	o Specify:		Specify: Whi	te		
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show the Medical Examiner must be motified at	Completed	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occ	upation		16b. Kînd of Business/l	ndustry		
215	hin 7 9. "n Med	ple	(Specify only highest grad	College (1-4or 5+)	life.	DO NOT use retii	e during most of w red)	vorking				
N	gien gien erth	Son		2		or Staff	Special	ist	Department	of Defense		
pu	al Hy	Be (17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle,	Maiden Sumame)			
yla	Ment Ment arkec	2	William Carroll				Ma	rgaret Bu	rke			
Maryland	iges 1 and 2 should be filled within 72 hours after death with the Marylan of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-1 show or other treumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationship (T)			-			er, City or Town, State, Zi			
	Health Health tem 27 other tre		Catherine B. Bell	i/ Daughte:			Street,		ngton, DC 2			
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any njury or other troope.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	20b. Place of Dispo cemetery, creations Gate of	nsition (Name of matory or other pr	lace) Ann	Date	20c. Location - City or T	own, State		
Ë			'4 ☐ Donation 5 XOther (Specify)		Ceme	tery	1171	2004	Silver Spr:	ing, MD		
Sali	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	Dreuk A	Fr	2. Name and Add	ress of Facility Collins	Funeral	Home Inc.			
_	g O 75 % 9		+ menian	ejura	50	0 Unive	rsity Blv	7d. W., S	ilver Spring	g, MD 20901		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the ne cause on each line.	ne death. Do not en:	er the mode of d	ing, such as cardi	iac or respiratory ar	rest,	Approximate Interval Between Onset and Death		
4	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final Immediate Country one cause on each line. Immediate Cause (Final Immediate Cause) Pneumonia 1									
8	/Medical		resulting in death)	Due to (or as a	consequence of):							
	Examiner		Sequentially list conditions.	U	Obstructi	ve Lung	Disease			Years		
	pe tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):							
	ecute and trans	am	that initiated events resulting in death) Last	c	-6							
60,	be executed sician and burial-transit	Ē		Due to (or as a	consequence of):							
68760,	ate hy	dical		d								
9 xo	death certific attending plater use as t	Physician/Med	IF FEMALE:	23c. If yes, outcome of	orogogogy.	1770 111111						
Bo	attend attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death 3	Ectopic pregnan	су		23d. Date of delive	ery Day Year		
	t the de by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at tir 9□ Unknown	ne or death 5	Other (specify)						
0	The law requires that the ate has been signed by th page 2 should be detache		Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cause o	iven in Part I	23e. Did to	bacco use contribute to	the cause of death?		
ds,	signed signed d be de	d by		3		, , ,			res 2 □ No 3 □ Pro			
ecords,	w require been si should b	ete					·-		045.144			
Rec	has has	Completed						24a. Was autop	sy prior to comed? death?	opsy findings available impletion of cause of		
								1 ☐ Yes	2⊠No 1□Yes	2 No		
Vital		Be	25. Was case referred to medical examiner?	Hospital:	-57		the are	eath (Check only o				
of	Phys this ral dj	2 2	1 ☐ Yes 2 ☒ No	1 L Inpatient	2 ER/Outpatier 28b. Time o	IL JUDON	4 ZMAUISING		lence 6 Other (Speci	fy)		
		lon	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	(ear) Injury	W	ork? □Yes 2□No	200. Describe i	low injury occurred			
2	or Attending after death. Director: Aftel in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injun	/ - At home, farm, str			28f. Location /S	Street and Number or Rur	al Route Number		
Division	l or Att after d Direct i in by	Certification:	4 Homicide determined	building, etc.	(Specify)	cot, lactory, office		City or Tow		ar riodic rambor,		
	To the Hospitel c		29a. Certifier 1 Certifying Phy	sician: To the best of	my knowledge deat	n occurred at the	time, date and pla	ce, and due to the	cause(s) and manner as	tated		
	o the Hospite ithin 24 hours o the Funerel ompletely filled	Medical	(Check only 2 Medical Exami	ner: On the basis of e	xamination and/or in	vestigation, in my	opinion, death oc	curred at the time, o	date and place, and due t	o the cause(s)		
	o thin o the	Me	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date signed (Month,	Day, Year)		
			1 Ruph	Cus-		D2	3958		March 29,	2004		
	115		30. Name and address of person who co	ompleted cause of dea	th (Item 23a) (Type		77-5			<u></u>		
			Burt I. Feldman			•	Blvd	Silver Sr	ring, MD 20	906		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	1		DP	-16, 110 20	,,,,		
	Registr		MAR 3 0 200	4 Sener	a B	Spork	2					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Yeer ANDREW MARCH 23, 2004 BERGMAN 9:38 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL **BETHESDA** MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. MAY 24, 19 5. Social Security Number Birthplece (State or Foreign Country)
 NEW YORK 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F 1957 Director 074-48-3414 46 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r Items 23a or 28e-f shov ther must be notified at 1 ☐ Yes 2 ☐ No Directo MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5801 NICHOLSON LANE, #1705 20852 UNITED STATES by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Peges 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ont Health and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: ial Hygiene. d other than "neturel", or if event, the Modical Example 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 DISABLED NONE injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BERGMAN SYBIL GOLDSTEIN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLIOT BERGMAN, 8100 MUIRHEAD CIRCLE, BOYNTON BEACH, FLORIDA 33437 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Reproval from State
1 ☐ Donation 5 ☐ Other (Specify) MT. ARARAT CEMETERY 3/26/2004 PINELAWN, NEW YORK 21. Signature of Juneral Service Liverises 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. free Jakes 1170 ROCKVILLE PIKE, ROCKVILLE, MD 23a. Parry. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Phermonia week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any learning immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Due to (or as a consequence of): .O. Box 68760, igned by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Acute Renal Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 🗷 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Central Sleep Aprica within 24 hours after death.

No the Funerel Director: After this certified completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) D0060 117 March 23, 2004 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, MD 20850 EricJ. Park, uD 31. Date filed (Month, Day, Year) MAR 29 2004 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

40/82/E

Bergman, Andrew

State of Maryland / Department of Health and Mental Hygiene

	Decedent's Name (First, Middle, Les	Otato or Marylan	•	ate of Death	2. Dete of D	Reg. No?	04 12172						
Physician					Month	Dey	Yeer 3. Time of Death						
/Medical	Elizabeth E. Bjor			45.00.7		24, 2004							
Examiner	4a Facility Name (If not institution, give	street end number)			own, or Location of Dee								
	Brighton Gardens	1		Rocks			gomery						
Funeral Director	5. Social Security Number 334-30-5171 6. Security Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. 100	Vrs.		Min. 8. Date of Bi (Month, D) Oct. 2	ey, Y <i>ear)</i>	9. Birthplace (State or Foreign Country) Iowa						
natural; or items 23a or 28a-f show dical Examiner must be nottlised at eted by Funeral Director	10a. State 10b. County	10c. City	y, Town or Location				10d. Inside City Limits						
28a-f ehow notified at rector	Maryland Montgome		kville				1 ☐ Yes 21X No						
28a-i	10e. Street end Number	Ly ROCE		Zip Code		10g. Citizen of	What Country?						
r Nems 23a or 28a-fe drer must be notified Funeral Director	5550 Tuckerman La			20852		United	States						
by by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		ecedent of Hispenic Of specify Cuban, Mexica s 211 No Specify	rigin? (Specify Yes or N n, Puerto Rican, etc.)	Specif	e - American Indian, ck, White, etc. White						
ted far	15. Decedent's Edu (Specify only highest gred	ucation	16a. Decedent's	Jsual Occupetion	et of working	16b. Kind of B	usiness/Industry						
rt, the Medical I	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	work done during mos T use retired)	si or working								
# P	_	4	Homemal	cer		Own Ho	me						
event,	17. Father's Neme (First, Middle, Last)			18. Moth	er's Name (First, Middle	, Maiden Suman	ne)						
TO B	Edward Evans			Jane	Grieves								
T	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,												
T.	Catherine B. Nelson/Daughter 12109 Piney Glen Lane, Potomac, Maryland												
any injury or other traumatic event, the Med pings. To Be Comple		Removal from State Cre	Place of Disposition emetery, crematory Montgor ematorium	or other place) nery . Inc.	March 26,	Bethesd	City or Town, State a, Maryland						
any Ir	4 Donation 5 Other (Specify) Crematorium, Inc. 2004 Bethesda, Maryland Signature of Funeral Service Lieogee 22. Name end Address of Facility Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenual Bethesda, Maryland 20814-3501												
ician	23e. Part1. Enter the direase, or comp shock, or least failure. List only of	lications that caused the deeth ne cause on each line.	n. Do not enter the	mode of dying, such as	s cardiac or respiratory	errest,	Approximate Interval Between Onset and Death						
edical	Immediate Cause (Final disease or condition	_ Cardiac Arr	est										
niner	resulting in deeth)	Φ	r es e consequence	of):									
ne r		Respiratory	Failure				5 minutes						
rens	Sequentially list conditions.	D	r as e consequence	of):									
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	Cerebrovasc	ular Acci	dent			48 hours						
Se es me bunal-trensit	resulting in death) Last	Due to (or	r as a consequence	of):									
for u													
atached for use	Part II. Other significent conditions co	ntributing to death but not resu	ulting in the underlyi	ng cause given in Part			ntribute to the cause of death?						
be datac						Yes 2K No	3 Probably 4 Unknown						
page 2 should					24a. Was	s en autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?						
Pag					10	Yes ZLINO	1 ☐ Yes 2 ☐ No						
Be C	25. Was case referred to medical examiner?			26. Plac	e of Death (Check only	one)	-02						
dirac	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4X N	ursing Home 5 Res	idence 6 □Oth	er (Specify)						
funeral	27. Manner of Death 1 12 Natural 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work? 1 ☐ Yes 2 ☐		how injury occur	red						
led in by tha funera Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - At he building, etc. (Specify	ome, farm, street, fa	ctory, office		(Street and Numb wn, Stete)	per or Rurel Route Number,						
To the Funeral Director: After this certificata has been signed by the attendir completely filled in by the funeral director, page 2 should be datached for use Medical Certification: To Be Completed by Physician/A		elclan: To the best of my known iner: On the basis of examination and manner stated.											
ompl Me	29b. Signature and title of certifier	, ()		29c. License number		29d. Date signe	d (Month, Dey, Year)						
0	× A	1/ Wa		DZ988	3	3/25	104						
	/	ompleted economic of death (**)	220) (Tuno Drint)	•		- 1	(- (
	30. Neme and address of person who c			. "010		Vm 055	•						
	Andrew V. Panagos ;			rive, #210	, Bethesda,	MD 208	1/						
State Registrar	MAR 2 9 201	32. Registrer's Signa	9 4	parks									

DHMH 16 Rev 6/95

			For State	State of Marylar	•				_	_	00	~ 1		
			1 - State Registrar/MEND#10a, b, c, e, 1. Decedent's Name (First, Middle, Last)	fperINF,4/6/04,	HW, Neer	uncau	e or D	eatri	2. Date of De	Reg. No	7 11]4	3. Time of Dea	13
	Physici /Medio		Nada Blagojev:	ic					Month March	21°	200	Year 4	11:20 F	м
	Examir		4a. Fecility Name (If not institution, give si	·				ocation of Dea	th	40	. County o	f Death		
			Potomac Valley Nur 5. Social Security Number 6. Sex	sing Home 7. Age (In yrs.	last hirthday)		Rockv	ille If Under 24 Hrs	8. Date of Bir		ontgo		ace (State or For	roien
	Funeral Director			M 2∑F 8		Months		Hours Min	. (Month, Da	ly, Year,)	Coun	oslavia	eign
	and		Usuel Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation						10	d. Inside City Lir	nits
	Maryl	to	Maryland Montgomery	Roc	kville ashingt								1 X Yes 2 □	
	or 28e	Olrec	10e Street and Number 1235 Potomac Valley Roa			10f. Zip	Code 850			10g. Ci	tizen of Wh	nat Coun	ry?	
	s 23a	rai	1954 Columbia Road	, N.W. #601		_	20009	_			US			
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28e-f ahow eumatic event, the Medical Exercited must be notified at	by Funeral Director	1 Never Married 2 Married	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	l II	Vas Deced IYes, spec I□Yes 2	ify Cuban,	panic Origin? (1 Mexican, Puer Specify:	Specify Yes or No to Rican, etc.))-	14. Race Black, Specify:	White, e	tc.	
8	2 hour	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a. Deced	lent's Usua	I Occupati	on		16b. K	ind of Busi	Whi iness/Ind		
Baltimore, Maryland 21215-0036	thin 72 e. an "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give		k done du	ring most of wo	rking				,	
21	led wi		8 17. Father's Name (First, Middle, Last)		Se	amstı		0 11-15-4-11-	man (Clark Adiatal)		lf-Em		ed	
anc	d be filed ental Hygi ted other c event, I	To Be	Branco Pejin						^{me (First, Middle,} Kacurin	Maider	Sumame,	,		
ary	should be tand Mental I	۲	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address			ural Route Numbe	er, City	or Town, Si	tate, Zip	Code)	
Z	and 2 ealth a n 27 ls		Michael P. Bentzen						e 520 Wa	sh.	D.C	. 20	006	
lore	it of H		20a. Method of Disposition 1 ★ Burial 2 Cremation 3 Re		Place of Dispos cemetery, crem	sition (Name natory or of	ne of ther place)		ph 25,	20c. L	ocation - C	ity or Tov	vn, State	
Itim	artmen ortant:		 4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service License 		ck Cree					Was	sh.,	D.C.		_
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other treumatic events.		I Amus El D		4		3 7 1331 333	2222 Washi	eVol Fun Wisconsi ngton, D	n Av	2000	V.W.		
	Pnysician /Medical Examiner	ner	23a Parti. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	Cardiac Ar Due to (or as a consect Dementia Due to (or as a consect Due to (or as a consect)	rythmia quence of):								Approximate Interval Between Onset and Death	
8760,	cate be executed physician and the burial-transit	dicai Examine	Cause (Disease or injury that initiated events resulting in death) Last	H ertensi Due to (or as a consec										
.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregn 1 Live birth 2 Fett 4 Pregnant at time of o	al death 3 🗌	Ectopic pro					23d. Date (Month		y Day Year	
ds, P	es De pe	by	Part II. Other significant conditions cont	ributing to death but not res	sulting in the un	iderlying ca	ause given	in Part I.		obacco (res 2	_		cause of death?	
Vital Record	The law te has t	Completed							24a. Was autop perfo 1 \(\text{Yes}		pric	ore autop or to com ath? Yes 2	sy findings availa pletion of cause	ble of
	Physicien: The this certiticate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	spital: 1 ☐ Inpatient 2 ☐	IEB/Outesties		Cohor		ath (Check only o		17.7			
n of	iding Phy Ih. : After this i tuneral d	on: To	27. Manner of Death 1 ∑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28	Bc. Injury a Work?	t	dome 5 ☐ Resident 28d. Describe h					
Division	or Atten titer deal Director. in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	M eet, factory		s 2 🗌 No	28f. Location (S City or Tox	Street an vn. State	d Number	o <i>r Rural</i>	Route Number,	
	e Hospital 24 hours a e Funaral l	edical (29a. Certifier 157 Certifying Physic (Check only one) Medical Examination	cian: To the best of my know: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred a estigation.	at the time, in my opin	date and place ion, death occi	e, and due to the ourred at the time,	cause(s) date and	and mann place, and	er as sta d due to t	ted. he cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	140		29c	. License n	umber		29d. Da	te signed (i	M onth, D	ay, Year)	
	V		1 2/35	MIMMEN!			D-59	284		Maı	ch 2	2, 2	004	
	(4)		30. Name and address of person who con Shahid Shamin, M.I			,	Silv	er Spr	ing, MD					
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 9 2004	32. Fegistrar's Sign			reds/							

			For State Registrar	State of I	Maryland	-			ealth a Death	ind Me		giene Reg. No	00	11.	10	1 77 1
			Decedent's Name (First, Middle, Last) 2. Date of D							2. Date of De.	eath 3. Time of Death					
	Physici		Daisy Adina Taylor Boyce March 2							29 Day	′ 2004	ear	5:15	рΜ		
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death							4c. County of Death						
			Fox Chase Nursing	Center			Sil	ver S	pring				Montg	ome	ry	
	Funeral		5. Social Security Number 6. Se	x 7. □M 2 ∑ F	Age (In yrs. la		If Unde Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Birl (Month, Da	v. Year)		Coun	place (State htry)	
	Director		313-32-3323	J M 200 F	74	Yrs.					July .	5, 1	929 T	rin	idad,	W.I.
	72 hours after death with the Maryland "natural", or tlems 23a or 28a-f ahow Utgal Examina", ual be natified at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									-	1	0d. Inside C	City Limits	
		ō									M☐Yes 2 ☐ No					
		Director								10g. Cit	izen of Wha	at Coun	ntry?			
		0	1413 Delafield Place, N.W. 20011							Uni	ted S	tat	es			
		Funeral	11. Marital Status	12. Was Decede	2. Was Decedent Ever in U.S. Armed Forces?			Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				No- 14. Race - American Indian, Black, White, etc.				
ထ္	or its		1 Never Married 2 Married	1 Tes 2		1			Specify:	, , , , , , , , , , , , , , , , , , , ,						
8	ural',	d by	3 Widowed 4 Divorced	Year or Date	ıs:										Ameri	can
<u>7</u>	I within 72 ho iene. r than "natur the Medical	ete	15. Decedent's Ed (Specify only highest gra			16a. Dece (Give	kind of w	ork done d	during most	of workin	g	16b. K	ind of Busin	ness/inc	Justry	
12	within ene. than "	To Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			DO NOT use retired) Lstered Nurse				Heal-			Lth		
Maryland 21215-0036	Hyg the tr		17. Father's Name (First, Middle, Last)				18. Mother's Name			r's Name	(First, Middle,	Maiden	iden Sumame)			
lan	os 1 and 2 should be of Health and Mental I Item 27 Is marked o r other traumatic eve		G 11 m 1						or B	or Best						
ary			19a. Informant's Name/Relationship (7	ype, Print)		19b. Maili	ng Addres	s (Street	and Numbe	r or Rural	Route Numbe	er, City o	r Town, Sta	ate, Zip	Code)	
	and 2 ealth a n 27 is		Cheryl A. Boyce	(daught	er)	1413	Dela	field	P1.	N.W.	, Wash	ingt	on, D	.C.	200	11
J.	tem Item		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Bomoval from St	1 00	ace of Dispo emetery, crea	sition (Namatory or	ime of other plac	e)	Da	ate	20c. Lo	ocation - Ci	ty or To	wn, State	
Ĕ	Pages nent of ant: If Its ury or o		'4 □Donation 5 □ Other (Specify		Gat	e of	Heav	en	4	/2/04	4	Sil	ver S	prin	ng	
Baltimore,	permil. Pages in Department of History in Italians any injury or ot once.		21. Signature of Funeral Service Licen	SOO H ()	V	, M	2. Name a	nd Addres	ss of Facility	Serv	vice,Ir	ıc.				
_	20 E 2 9		23a. Part1. Enter the disease, or com	produ	jun	7	400 (Georg	ia Av	e.,N	.W., Wa	shi	ngten	, D.	C. 20	0012_
	Physician /Medical Examiner	J.	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or	n ine. leimer [†] as a consequ	s Deme									Interval Be Onset and	
	ate be executed hysician and the burial-transit	ng.	if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury	Due to (or as a consequence of):												
		Examine	that initiated events resulting in death) Last	c. Due to (or	C											
8760,	siciar buril	dlcal		d												
189	ificate g phy as the	edic		· · ·												
Vital Records, P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown							23d. Date of delivery Month Day Ye			Year		
	juires that n signed b ild be deta										cco use contribute to the cause of death? 2 No 3 Probably 4 Mnknown					
S	w requir s been si should	lete									24b. Were autopsy findings available					
Re	The lav	To Be Completed								autor perfo	psy ormed? 2⊡ No	dea	ith?	mpletion of 2⊠No	cause or	
tal			25. Was case referred to medical						26. Place	of Death	(Check only o	_4		1103	222110	
<u>></u>	Physician: The this certificate har director, page		examiner? 1 ☐ Yes 2 【X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ※ Nursing					rsing Horr	Home 5 ☐ Residence 6 ☐ Other (Specify)						
υot			27. Manner of Death 1 XNatural 5 Pending	be 390 Place of Injury At home form street					2	28d. Describe how injury occurred						
io	Attending r death. ector: After by the fune	atlo	2 Accident investigation						No	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
Division	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the t	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined				reet, facto	et, factory, office 28						mber,		
		Medical ((s)			
	To the within To the comp	Ž	29b. Signature and title of certifier				29c. License number D 28656			29d. Date signed (Month, E			Day, Year)			
•	'n		Bass			April 1, 2004										
	(30. Name and address of person who	completed cause	of death (Item	23a) (Type,	Print)									
				2nd Ave			pring	, Ma	rylan	d						
ri,	Si	ate	31. Date filed (Month, Day, Year)	32. Rec	gistrar's Signa	ture 4	A	1 120 H	1							

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Certificate of Maryland / Department of Ficality a	na wena riy	Reg. No. 20	04 12175							
П	Dhysisian	Decedent's Name (First, Middle, Last)	2. Date of De	eth Dey	3. Time of Death							
	Physician /Medical	Mary Varney Brady		26, 2004								
	Examiner	4a Fecility Name (If not institution, give street end number) 4b. City, Tow	n, or Location of Deeth	4c. County								
		Holy Cross Rehabilitation & Nursing Center Burtonsville Montgomery										
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 2. Months Days Hours	8. Date of Birt (Month, Da	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Forei Country)								
	Director	218-24-3115	July 7									
	P	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City 1										
	anyti eho		1-☐ Yes 2 ☐ No									
	vith the Ma or 28a-f s be nottred Director	Maryland Montgomery Takoma Park 10e. Street end Number 10f. Zip Code	10g. Citizen of What Country?									
	ath with the Marylan 23e or 28e-f show ust be notified at rei Director	Toe. Street end Number 105. 2ip Code 10g. Citizen of What Country?										
	r tteme 23 inst. must Funeral	436 Lincoln Avenue 20912 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispenic Original Conference of	in? (Specify Ves or No	USA 14 Bac	e - American Indian,							
_	Heme Instru	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No 1 □ No	Puerto Rican, etc.)	Blac	ck, White, etc.							
22	urs after des el', or tiems Examiner m by Fune	If Yes, Give 1 ☐ Yes 2 ☑ No Specify: 3 ☒ Widowed 4 ☐ Divorced Year or Detes:		Specify	and the second s							
ŏ	72 hours after death with the Maryland Insturel; or theme 23a or 28a-f show adreal Examiner must be notified at leted by Funeral Director	15. Decedent's Education 16a. Decedent's Usual Occupation		White 16b. Kind of Business/Industry								
21215-0020	⊆ 5 5	(Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired) (Give kind of work done during most of life. DO NOT use retired)	of working									
21	filed with Hygiene. ther ther and, the	2 Homemaker		Own Home								
פ	E155		s Name (First, Middle,	e (First, Middle, Maiden Surname)								
<u>a</u>	Mentel Mentel arked o atic eve	Charles Varney Mar	v Byrne	Rurno								
Maryland	S E E	Charles Varney Mar 19a. Informant's Name/Relationship (Type, Print) Son-in-Law		r, City or Town,	State, Zip Code)							
Σ	and 2 alth e 27 is	Russell C. Showers, Jr. 6 Delta Court Gai	thershura	MD 208	182							
Sre	of Heal of Heal I Item 2 r other	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location	City or Town, State							
Ĕ	0 0	1⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cemetery	3/30/04	C41	Spring,MO							
Baltimore,	mit. Pe sartmen sortant:	21. Signature of Funeral Service Licenses 22. Name end Address of Facility Francis J. Collin		PITAGE	aprins, ro							
00	20 5 2 2	500 University R	ns runeral 15d U Ci	Home, 1	.nc.							
		23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn deliure. List only one cause on each line. Solution										
May .	Physician	snock, or heart mailure. List only one cause on each line.			Interval Between Onset and Death							
	/Medical	Immediate Cause (Final	ebrovascular Accident									
П	Examiner	disease or condition resulting in death) e. Ce tebro vasculat Accide Due to (or as a consequence of):	211		1							
	je je	parto (of and a control quento con).			1							
	rificate be axecuted no physician and as the burial-transit	b										
Ó	a axe	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury c.			\$ 1							
68760,	ng physicia as the bu	Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of):										
	ng plans the Mec			1								
Вох	at the deeth cer d by the ettendin etached for usa Physician/N	d										
-	5 e 5 m	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did t	23b. Did tobacco use contribute to the cause of death?								
0	requires that the de seen signed by the e hould be detached f		101	1 ☐ Yes 2 ◯ No 3 ☐ Probably 4 ☐								
	bed by		-									
5	requir been s should		24a. Was e		24b. Were autopsy findings available prior to							
Records,					completion of cause of death?							
<u> </u>	The lew ata has page 2 (Comple		104	65 25 4 (No	1 ☐ Yes 2 ☐ No							
Vita	ysiclan: The sis certificata diractor, pag		of Death (Check only or	10)								
<u></u>	Z v D		sing Home 5 🗆 Resid	ence 6 □Othe	or (Specify)							
n of	ng Phy ter thi neral	27. Manner of Death 1 ☑ Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	28d. Describe how injury occurred								
Ö	Attending or deeth. Ctor: After by the fune iffication	2 Accident investigation M 1 Yes 2 No)									
Division	tal or Attending P rs after death. al Director: After t led in by the funers Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury · At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	tal or is after in led in Cert											
	To the Hospital or Attending I within 24 hours after deeth. To the Funeral Director: After completaly filled in by the funer Medical Certification	29a. Certifier (Check only 2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death	place, and due to the coccurred at the time.	ause(s) and mar	nner as stated. and due to the cause(s)							
	hin 2 the f	one) and manner stated.										
,	70 Maria Molament D25348 3/26/04											
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARKIA Goldmink, M.D. 11906 Darnestown Rd. N. Potomac, Md 20878												
	State	31. Dete filed (Month, Day, Yeer) MAR 2 9 2004 32. Registrar's Signature										
	Registrar	MIMIN WO LUUY Aparts										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2004^{Year} Month March 22, **Physician** Jack David Bruner 11:24 P M /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 01ney Montgomery Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 22, 2004 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Months Days 1<u>⊠</u>M 2□F Hours Maryland Director None Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County rai', or items 23a or 28a-f show Examiner must be nutified at 1 ☐ Yes 21 No Maryland Montgomery Gaithersburg Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20878 333 Swanton Lane United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Infortant: If tem 27 is marked other than "natural", or itel any injury or other traumatic event, the Medical Examines any injury or other traumatic event, the Medical Examines and injury or other traumatic event. 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) None None 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) David Lawrence Bruner Jessica Ann Drumm 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) David Lawrence Bruner/Father 333 Swanton Lane, Gaithersburg, Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition March 26, 2004 1 Burial 2 □ Cremation 3 □ Removal from State All Souls Cemetery Germantown, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. M00198 0 300 West Montgomery Ave., Rockville, MD 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypoxia /Medical Due to (or as a consequence of): **Examiner** Tracheal Atresia Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause, pusease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the use as I IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 9 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? this certificate 1 Yes 2 No 1 🗆 Yes or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner' Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 XNatural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Dath signed (Month, Day, Year) D0059621 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18111 Prince Philip Drive #207, Olney, Maryland 20832 Honghanh Lisa Nguyen, M.D.

State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Edward

DHMH 17 Rev 1/2001

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 2004 1 2:00 April Hazel Louise BARKDOLL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood Nursing Home Williamsport Washington If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 214-46-5080 84 March 11 1920 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f ehov the Medical Examinar must be notified at 1 Yes 2X No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 U.S.A. 17308 Lexington Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ If Yes, Give Year or Dates: Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 10 0 Homemaker Her own home marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if item 27 is marked othe any injury or other traumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lester Mose, Sr. Mary Calbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles H. Barkdoll - Husband 17308 Lexington Avenue Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 4/5/04 Hagerstown, Maryland 21. Signature of Euneral Service Licenses 21 Name and Address of Facility Minnich Funeral Home E. Wilson Blvd. Hagerstown, Md. 23a. Farth. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Conti Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medicai as attending IF FEMALE: **BSU** 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy ŏ Day Year 5 Other (specify) the s Division of Vital Records, P.O. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying 23e. Did tobacco use contribute to the cause of death? Completed by been si 1 Yes 2/2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 200 No 1 ☐ Yes 2 ☐ No 1 Yes ector. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 25 No ို 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this Director; After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide hours after within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print)

State Registrar

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ORIGINAL

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 () 2. Date of Death Decedent's Name (First, Middle, Last) Year Mont **Physician** 2:30 AM 2004 Marc Grace Loretta BOWLES /Medical 4c. County of Deat 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March | 8 | 1936 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗓 F 68 Maryland Director 219-34-7471 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County ral', or Items 23e or 28e-f ahow Examiner must be notified at N☐Yes 2☐No Directo Maryland Hagerstown Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Apt. 409 21740 11 W. Baltimore Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritat Status ges 1 and 2 should be filed within 72 hours after (it of Health and Mental Hygiene. If Item 27 is marked other than "natural" or Hea 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: δ White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Housekeeper **Hospital** 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Washington Harbaugh Marguerite Elizabeth Garmong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once. Lucille Richardson - Sister 506 Bentley Court Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removat from State * 4 □ Donation 5 □ Other (Specify) Hagerstown Crematory 4/1/04 Hagerstown, Md. 21740 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 200 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) Gastrointestinal Physician /Medical Due to (or as a consequence of): Examiner Heart Cong Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Renal physician and the burial-transit The law requires that the death certificate be executed chronic that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetat death 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 1 Yes completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 ☑Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10060396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) em 23a) (Type, Print) 1126 Opal Court Hagerstown SHED ARID 31. Date filed (Month DDay, (Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 Month March 30, **Physician** 7:00 p.M Dorothy Ellen BIRO /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Avalon Manor Hagerstown Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Yea July 7, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1 ☐ M 2 🖾 F 87 Maryland 213-16-0357 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County s 23a or 28e-f show 1 X Yes 2 No Director Marvland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11 W. Washington Street 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after deinent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items iny or other traumatic event, the Modical Examilian. Black, White, etc. 1 Never Married 2 Marned 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: white þ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker her own home 18. Mother's Name (First, Middle, Maiden Sumame) 17, Father's Name (First, Middle, Last) Be Joseph Holmes Mears Hulda Helman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 E. Washington St., Hagerstown, Md. 21740 Ruby Joyce Wolfe - niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If It any injury or o 1 Burial 2 Cremation 3 Removal from State Hagerstown Crematory 4/01/04 Hagerstown, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME COL 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phennans 1000 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 4 mknown dis Varanten Completed 24b. Were autopsy findings available prior to completion of cause of death?

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier muzen 31, 2004 D(80(5 -text mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAGERSTOWN MO 21740 MILLST DATTHMO 340 VASANT 31. Date filed (Month, Day, Year) APR 0 2 2004 32. Registrar's Signature State perse Registrar

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	F		5. Social Security Number 9 6. S		(In vrs.	HCV last birthday)	If Under	1 Year	Hur If Under	2 Hrs.	8. Date of Birt	14	/ COTILE	place (State or I	Cossien
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Maryland 21215-0036		To Be	DAVID C. COOPER								NE BENZ		,		
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Baltimore,	ite it		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from State	20b. Pl	lace of Dispo emetery crem SON S	sition (Nam	e of her place)		Date	20c. Locat	tion - City or T	own, State	ı
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 3 JOAN FRANCES CORDIERO /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Atlantic General Hospital Berlin Worcester 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 8-7-38 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2 1 F 578-50-6222 65 Yrs. Md. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at Md. Worcester 1 Yes 2 No Ocean Pines Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Poacher Trail 21811 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Secretary Lega1 or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked 1 any injury or other traumatic eventages. John Paul Ward Greta Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernest V. Cordiero/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crem. 3-20-04 Salisbury, Md. 21. Signature of Funeral Services 22. Name and Address of Facility Ullrich Funeral Home Berlin, Md. 21811 23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** browles st. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🗹 No Certification: To 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death.
To the Funeral Director: A completely filled in by the fo 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier unskil 30. Name and address of person who completed cause of deal (Item 23a) Type, Print) 32. Aggistrar's Signature 31. Date filed (Month, Dey, Year) MAR 2 2 2004 MUR Registrar

22215-0036 138 - 3/19/04

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Saltimore, I

P.O. Box 68760

Division of Vital Records,

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			Registrar		Certifica	te of Death	Reg. N	<u>. 200</u>	4 12 185
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	Funeral		Social Security Number 6.	Sex 7. Age (In yrs	s. last birthday) If Und Months	er 1 Year If Under 24 Hrs		9. Bir	thplace (State or Foreign
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7	- >		Usual Residence of Decedent 10a. State 10b. County	100.7	7 T				
	sho	-	10a. State 10b. County	100.0	City, Town or Location				10d. Inside City Limits
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3	He H	Ë	11. Maritål Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces?	If Yes, sp	edent of Hispanid Origin? (S ecify Cuban, Mexican, Puer	specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
39	, o	by	3 Widowed 4 Divorced	1 Tyes 2 No If Yes, Give A Year or Dates:	1 🗆 Yes	2 No Specify:		Specify: P	last.
5-0036	atura	be	15. Decedent's I	Education	16a. Decedent's Us	ual Occupation	16b.	Kind of Business	Industry
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פ	al Hygi	Be	17. Father's Name (First, Middle, Las	st)	_	18. Mother's Na	me (First, Middle, Maide	n Sumame)	
Maryland 2121	and of Mental Hygiene. Markad other than "natural", or Hema 23a or 28a-1 show marked other than "natural", or Hema 23a or 28a-1 show mastic event, the Medical Exercities mant to notified at	10	Charles H	: + letcher	· Sr.	Hes.	ter Sa	Vano.	
العار			19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Addres	ss (Street and Number or R	ural Route Number, City	or Town, State,	Zip Code)
	Health tem 27 other tr		Varice Colli	ins (daughter	1246 50	10 w Hill Rd	Stockto	on mo	2/864
ore	of Health If item 27 or other tr		20a. Method of Disposition 1 Burial 2 Cremation 3		Place of Disposition (Na cemetery, crematory or	ame of other place)	Date 20c.	Location - City or	Town, State
altimore,	ortant: j		'4 □Donation S □ Other (Spec	sify)	OSprine C.	enter 3-2	2-04 6-1	odle to	ce md.
Balt	Domini Importa any inj		21. Signature of Funeral Service Lice	ansee []		and Address of Facility B	ennie 5	11/2 I	112-14
m i	20129	11	should	Jan	P.O. B	0x371 POGO	make Cit	-u mil	2/851
- 13			23a Part Ener the disease, or con shock, or heart failure. List on	mplications that caused the dealy one cause on each line.	ath. Do not enter the mo	oe of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between
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7		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):				
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x 68	attending p	Physician/Med	IF FEMALE:						
Box	or us	an	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel	tal death 3 □Ectopic i			23d. Date of del Month	ivery Day Year
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عَ عَد	ed by detac	P.	Part II. Other significant conditions	contributing to death but not re	esulting in the underlying	cause given in Part I	23e Did tobacco	usa contributo to	the cause of death?
Records,	been signed to should be deta	1 by		ormound to double hot hot ho	outing in the underlying	cause given in rait i.	1 Tes 2		obably 4 Dunknown
Ö	peen	Completed						7	obably 4 Doriniowii
je je	page 2 s	mpi					24a. Was an autopsy	prior to d	topsy findings available completion of cause of
							performed?	death?	2 No
Vital	certif	Be	25. Was case referred to medical examiner?	Hospital:		0.1	ath (Check only one)		
o d	this ral di	: To	1 Yes 2 Yo	1 Inpatient 2	☐ ER/Outpatient 3☐ D 28b. Time of		lome 5 Residence		cify)
ב ב	After fune	tion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ry occurred	
ISI Tal	deati	Certification:	3 ☐ Suicide 6 ☐ Could not	be Ose Bless of leaves At I			28f. Location (Street a	nd Number or O	Isal Pouto Number
Division of	Dire Dire	erti	4 Homicide determined	building, etc. (Spec	erfy)	ry, diffice	City or Town, Stat	a)	irai noute ivumber,
4	neral fillec		29a. Certifier 1 Certifying P	Physician: To the best of my kn	owiedge, death occurred	f at the time, date and place	and due to the cause/s	l and magnet as	stated
1	24 h e Fur etely	Medical	(Check only 2 Medical Exa	aminer: On the basis of examin and manner stated.	ation and/or investigation	n, in my opinion, death occu	rred at the time, date an	d place, and due	to the cause(s)
	within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Me	29b. Signature and tille of certifier		29	c. License number	29d, Da	ite signed (Month	n, Day, Year)
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	2		30. Name and address of person who	o completed cause of death fits	m 23a) (Type, Print)		//'		, , , , , ,
·H	, H			14 MT /N /		E. Carrol	1151 3	Tal. 5.5.	UC - 140.
	Sta	te	31. Date filed (Month, Day, Tear)	32 Hegistrar s Sign	nature			, , , ,	/
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Charles

State of Maryland / Department of Health and Mental Hygiene 2004 Amend Item/19b per State of Maryland / Department of Health a Registrer Anne Arundel Co. Health Dept. BEM Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death March **Physician** 200410:35A м Virginia Chapman /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Severn 1507 Florida Ave If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1□ M 2□√F Yrs. Director 84 1919 Virginia 226-28-0547 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits rthan "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at 1 TYes 2 □ No Maryland Anne Arundel Severn Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1507 Florida Avenue 21144 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ➡No Specify Specify: þ **Black** XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 3rd Domestic Private Family 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Itam 27 Is marked o 2 Henry C. Ford Mamie Bishop 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code)
Wm. Reese & Sons Mortuary, P.A.
821 Vest St. Ambapolis Md. 21401 19a, Informant's Name/Relationship (Type, Print) Maxine Tucker (Daughter) 20b. Place of Disposition (Name of 1507 Florida Ave. Seven, Mbit 1124 or Town, Stelle cometery, crematory or other place) 20a. Method of Disposition Important: If It any injury or o once. 1 ™ Burial 2 Cremation 3 Removal from State Hill Crest Cemetery 4/6/04 Annapolis, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Larry & Reese Moo483 Wm. Reese & Sons Mortuary, 23a. Part1. Enter the Isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician arture Ovo hory resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the attending physician and thed for use as the burial-tran-Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 XNo 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 № No 24a. Was an has autopsy performed? certificate 1 Yes 2 No Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Z. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 29b. Signatura

30. Name and address of person who completed cause

Simple

2

of death (Item 23a) (Type, Print)

MD

29c. License number

D38958

Annapily Road #106 oclenton MD 21113

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 6:00 MILDRED IRENE CLABAUGH 2004 Ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Glade Valley Nursing Home Walkersville WAIKELS VIIII

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | June 4, 9. Birthplece (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1□M 2K1F Months 1909 94 220-68-2986 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or Items 23a or 28a-f ehow other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Directo Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 Victor Drive 21788 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 14. Race - American Indian, Black, White, etc. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced "naturel" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Peges 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If Item 27 Ie marked other than "in eny injury or other traumatic event, the Musil 2008. Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Shriner Bertha Valentine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Finneyfrock (Daughter) 48 Blue Ridge Avenue, Thurmont, Maryland 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Haugh's Church Cem. Ladiesburg, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 4/12/04 ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. EAST MAIN STREET, THURMONT, MD 21788 Approximate Interval Between Sure Poset and Death 23a. Part1. Enter the disease, or complications the shock, or hear failure. Liet only one cause of Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-transit the attending physician and Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has autopsy performed 1 Yes 2. No 1 ☐ Yes 2□ No Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 Yes 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: / 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours in To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) MD 21107 Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 0014 12189 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** ROBERT LEWIS CLEM SR MARCH 30 2004 7:45 P [™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours 1**⊠**M 2□F Yrs. Director 220-28-2985 74 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits item 27 Is marked othar than "natural", or Itams 23a or 28a-f show othar traumatic avant, the Medical Examinar must be notified at Directo 1 ☐ Yes 21 No Maryland Frederick Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4239 Old National Pike 21769 by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes · 2 🖾 No Specify: White 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) 10 Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Raymond Clem Edith Bidle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen A. Clem / Wife 4239 Old National Pike Middletown, Maryland 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State April 3, 2004 ` 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial Gar. Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or p spiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Onset and Death 1965/mi Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Un Kin son Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Denknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 Yes 2 No 1 Yes To the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 21 NO 2 ER/Outpatient 2 1 Dipatient 3□ DOA After thi funeral of 27. Man of Death 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after within 24 hours af To the Funaral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 amas Ma 1 14 31. Date filed (Month, Day, Year) 32. Registar's Signature State 2004 Registrar

			For State of Maryland		irtment of Ho tificate of E			giene∠UUL 1eg. No.	12190
			Decedent's Name (First, Middle, Last)				2. Date of Dea	ath _	3. Time of Death
1	Physicia		Nora Lucille Clevenger				April	03 2004	10:10 AM
>	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	1	4c. County of Dea	th
			Carroll Lutheran Village		Wes	tminster		Carr	oll
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	y, Year) 9. Bir	thplace (State or Foreign ountry)
	Director		232 - 22 - 4428 1□ M 2XF 91	Yrs.			Jan. 19	, 1913 Wes	t Virginia
	pu *		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	cation				10d. Inside City Limits
	aho	5		Westmi					1 X Yes 2 No
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	72 hours after death with the Maryland natural', or Itams 23a or 28a-f ahow lical Examinar must be notitled at	급	200 St. Mark Way		2115	R		USA	-
	ns 23	Funeral	11 Marital Status 12. Was Decedent Ever in U.S	. 13. V	Vas Decedent of His	spanic Origin? (S	pecify Yes or No-	14. Race - Am	erican Indian,
' 0	fter d r Itan	ᇤ	Armed Forces? 1 ☑Never Married 2 ☐ Married 1 ☐ Yes 35 ☑No	11	Yes, specify Cubar	n, Mexican, Puert	o Rican, etc.)	Black, Whi	te, etc.
036	ol', o Eran	þ	3 ★Widowed 4 Divorced If Yes, Give Year or Dates:	1	☐ Yes 211 No	Specify:		Specify:	White
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2	within ene. then "	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life. D	OO NOT use retired)			D 1	
21	e filed within al Hygiene. other then vent, the Me	S	8		Waitress	-	- (Fina Middle	Resta	urant
Maryland 21215-0036	D TO D S	Be	17. Father's Name (First, Middle, Last) John William Harrison Clevenger	. Jr.				Maiden Sumame) e "Kate" S	chrader
y Ja	Mer Mer arke	ို		<u>.</u>	- Address /Carnet n			r, City or Town, State,	
Mai	12 sho h and 7 la ma trauma		19a. Informant's Name/Relationship (Type, Print) Wilma Lough/Daughter						
d)	s 1 and 2 if Health item 27 other tra		20a Method of Disposition 20b. Pla	ice of Dispos	sition (Name of		Date	ter, MD 21	Town, State
ğ	nt of or		1 Burial 2 □ Cremation 3 ☑Removal from State	metery, crem	natory or other place igs Cemete	erv 04/0	7/2004	20c. Location - City or Diana, WV Webster Sp.	rings. W.Z.
Baltimore,	it. Partment		*4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee		- Indiana				Emgs, W
Ba	permit. Pages 1 Department of h Important: If its any injury or ot			-E	12 Wachir	neral Ho	ne & Chai	pel, P.A. inster, MD	01157
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alF							1 ☐ Yes	2 No 1 Yes	2 □ No
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of		. To	27. Manner of Death 28a. Date of Injury	R/Outpatien 28b. Time of				ence 6 Other (Spe	ecity)
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Division	l or Attending after death. Director: After In by the fune	Certification;	3 Suicide 6 Could not be 28e. Place of Injury - At hor	ne, farm, stre	eet, factory, office		28f. Location (S	Street and Number or R	ural Route Number,
ΕÌ	F & F C	erti	4 Homicide building, etc. (Specify)		1		City or Tow	n, State)	
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	To the Hospitel of within 24 hours at to the Funeral D completely filled in	edical	(Check only 2 Medical Examiner: On the basis of examinate one) and manner stated.	on and to inv	estigation, in my op	inion, death occu	rred at the time, o	date and place, and du	e to the cause(s)
	To the Ho within 24 i To the Fu completely	×	29b. Signature and title of certifier		29c. License			29d. Date signed (Mon	
	121)		· (That	,	D37	1949		April 5th	2004
	1.80		30. Name and address of person who completed cause of death (flym	23а) (Туре,	Print)				
	8		Alexander Bordascherslen Ke	5, 29	5 Stine	~ Hue	Weser	unisce, N	2004 0, 21157
	Sta Registi		31. Date filed (Month, Day, Year) 32. Jegistrar Signati	Ire A	a.V.				

State of Maryland / Department of Health and Mental Hygiene 2004 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death March 29, **Physician** Day LeRoy Lindy Conaway 2004 5:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral ₩** M 2□F 73 214-28-0984 Yrs. Director 4/28/1930 MARYLAND Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at MD CARROLL Director WESTMINSTER 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 255 EAST MAIN ST. 21157 USA Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1℃ Yes 2 □ No 1 9 5 2 If Yes, Give Year or Dates: 1 9 5 4 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: ρ 3 ☐ Widowed 4 ☐ Divorced 1954 WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) OWNER STORE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ith and Mental H 27 Is marked of treumatic ever JAY W. CONAWAY AMY FLEMING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l 255 E. MAIN ST., WESTMINSTER, MD. 21157 JANET L. CONAWAY - WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. EBENEZER CEMETERY 4/1/04 WOODBINE, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury Due to (or as a consequence of): nding physician and use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No director Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 Dopatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 🗌 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funerel Direct completely filled in by 4 Homicide the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI D25443 GTIJA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIDDLETON, MD 688 POOLE RD., WESTMINSTER, MD. 21157 31. Date filed (Month, Day, Year) 32. Registar's Signature State MAR 3 1 2004 leen & Sparke Registrar

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Balti	permit. Pad Department Important: any injury o		21. Signature of Funeral Service Licente	tayle!	١	1	Name and 722 N	Address	of Facility H CAI	TAYLOR	R'S E ST.,	LVER S FUNERAL NW WAS	HOME	
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DESILIMOTE, IMBITYIBING ZIZID-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f ahow any injury or other traumatic event, the Modical Examinar must be notified at page.	To Be Completed by Funeral Director	10a. State 10b. County D.C. 10e. Street and Number 5437 Connectic 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edur (Specify only highest grade (Specify)) 17. Father's Name (First, Middle, Last) P 19a. Informant's Name/Relationship (Tyle Anne-Marie C. K. 20a. Method of Disposition 1 Burial 2 Cremation 3 R. 4 Donation 5 Other (Specify) 21. Signature of Funeral Section (Specify)	wash. ut Ave. #204 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 KNo If Yes, Give Year or Dates: cation 16a College (1.4or5+) asquale Cimin elly P.O.A. completed Properation emoval from State Metrop	a. Decedent's Usua (Give kind of world) in the DO NOT us to the English of the En	ool 5 ent of Hispanic Originist Cuban, Mexican, Figure Value of Hispanic Originist Cuban, Mexican, Figure Value of Hispanic Original Cocupation (A done during most of the retired) 10 yed 18. Mother's Anna (Street and Number of Scomare the of Hispanic Original Cremator d Address of Facility N.W. Cra	Programment of the state of the	USA 16b. Kince Ret Maiden S. O 20c. Loca Alex uner Bow	Town, State, 2 eles, eles, ation - City or and ria	rican Indian, a, etc. te Industry ales Inp Code) 90077 California Town, State a, VA. me d. 20715
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ffer ng	Certification; To Be	examiner?		Time of 28 Injury M	A Other: 4 A Nursir dc. Injury at Work? 1 Yes 2 No	Death (Check only or on p Home 5 Resid 28d. Describe h 28f. Location (S City or Tow	ence 6 [ow injury o	occurred	ral Route Number,
To the Hospital or Attendi within 24 hours after death, To the Funarel Director: A completely filled in by the tu	Medical Co	29a. Certifier (Check only one) 29b. Signature and title of certifier	ician: To the best of my knowledg leer: On the basis of examination ar and manner stated.	nd/or investigation,	at the time, date and p in my opinion, death of License number 22780	accurred at the time, o	late and pl	nd manner as ace, and due signed (Month), h 29,	, Day, Year)
St Regist	ate	30. Name and address of person who co Peter M. Schis 31. Date filed (Month, Day, Year) MAR 3 0 2004			way Ctr.	Drive, (Greei	nbelt,	Md.20770

-··	1 - For State Registrar	State of Man		artment of He tificate of D			^	004	12191
Physician /Medical	Decedent's Name (First, Middle, Las	Robert	Harrison	Crawford		2. Date of Dea Month March	27,	2004	3. Time of Death 9:41 P
Examiner Funeral	Social Security Number Social Security Number	ty Hospital	n yrs. last birthday)			8. Date of Birti	Pr	ince Ge 9. Birthp	eorge's blace (State or Foreignity)
Director	Usual Residence of Decedent 10a. State 10b. County		75 Yrs. Oc. City, Town or Lo			August	11, 1	928 Wa	ashington Od. Inside City Limits
alter death with the Ma ritams 23a or 28a-1 s riner must be riciffies Funeral Director	Maryland Prince (10e. Street and Number 5999 Emerson Str		B	ladensburg			10g. Citizer	n of What Cour	1½ Yes 2 No
within 72 hours after death with the Maryland ene. 9ne. 1ne natural; or itams 23a or 28a-f show the Madical Examiner must be notified at my myleted by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1X Yes 2 □ No	L945	Vas Decedent of Hisp f Yes, specify Cuban,		ecify Yes or No- Rican, etc.)		Race - Americ Black, White, pecify: Whi	etc.
ed within 72 ho ygjene. har than *naturi t, the Medical I t, Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de co <i>mpleted)</i> College (1-4or 5+)	16a. Decec (Give life. L	lent's Usual Occupati kind of work do ne du DO NOT use retired) Bricklaye	ring most of worki	ing		of Business/Ind	dustry
should be filled and Mental Hygi a markad othar umatic evant, I	17. Father's Name (First, Middle, Last)		19h Mailin		8. Mother's Name F1	rances I	Rainey	Y	Code
permit. Pages 1 and 2 should be lifed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene and Informatical Examiner must be notified at one injury or other traumatic event, the Medical Examiner must be notified at one. To Be Completed by Funeral Director	Mary E. Crawford 20a. Method of Disposition 1	(Wife)	5999 Ob. Place of Dispo cemetery, cren	Emerson S sition (Name of patory or other place) Vet Cemete	Street #	719, Bla	adensk 20c. Locat		20710 wm, State
permit. Departm Importa any inju once.	21. Signatur of Fineral Service Licens		22	Name and Address	of Facility Rend	don/Hale	e Fune	eral Ho	me
physician and important transit and importan	ii any, leading to infinediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	Metast Due to (or as a co	nsequence of): ninated I:	state Cano		ılation			Interval Between Onset and Death
lat the beath certified by the attending phetached for use as the Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d.	Date of delive Month	ry Day Year
e has been signed age 2 should be d	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the un	derlying cause given	in Part I.	1 Ye 24a. Was a autops perforr	n 24	o 3 Proba	e cause of death? ably 4 Unknown by findings available of cause of
this certifical director, I	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatient 28b. Time of Injury	3□ DOA Other: 28c. Injury at Work?	6. Place of Death 4 Nursing Hon 2 5 2 No		e) ence 6 🗆		
a di di di di	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	pecify)	et, factory, office	2	28f. Location (St City or Town	n, State)		
n 24 h ha Fu pletely	(Check only 2 Medical Exami	sician: To the best of moner: On the basis of exa and manner stated.	y knowledge, death mination and/or inv	estigation, in my opini	on, death occurre	ed at the time, da	ate and plac	ce, and due to	the cause(s)
To the country of the	29b. Signature and title of sortifier	7					,	gned (<i>Month, E</i>	
9 1/a	30. Name and address of person who coccil George, M. 31. Date filed (Month, Day, Year)		Hanover	Parkway,	Greenbel	t, MD 2	0770		

	5549.		For State Registrar	State		nd / Depa		lealth and M	lental Hygi		004	1219
	Physicia	n	1. Decedent's Name (First, Middle Herbert M.						2. Date of Death Month March	Day	Year 2004	3. Time of Death 6:45 A M
	/Medica Examine		4a. Facility Name (If not institution		umber)			r Location of Death		4c. County	of Death	
×			Southern Mary 5. Social Security Number	land Hosp		. last birthday)	If Under 1 Year	Clinton If Under 24 Hrs.	8. Date of Birth			George's
	Funeral Director		709-12-4682 Usual Residence of Decedent	1 X)M 2□F	91	Yrs.	Months Days	Hours Min.	May 12,	1912	Was	tace (State or Foreign try) h., DC
	death with the Maryland ims 23a or 28a-f show ims 2 be realified at	Į	10a. State 10b. Count	у	10c. C	ity, Town or Lo		shington			1	0d. Inside City Limits 1X Yes 2 □ No
	or 28a	Director	10e. Street and Number				10f. Zip Code		109	g. Citizen of V	What Cour	ntry?
8	s 23s		4505 B St.		101	10 10		20019				States
50 C.	after or Ite	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	rried 1 Tes	2 XNo	1	Was Decedent of H fYes, specify Cuba 1 ☐ Yes 2 ☆ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		e - Americ ck, White,	
7.0	n 72 ho natur	Completed	15. Decede (Specify only high	nt's Education est grade completed	i)	16a. Deced (Give life.	lent's Usuaf Occup kind of work done OO NOT use retired	ation during most of worki	ing 16	Sb. Kind of Bi	usiness/Ind	dustry
212	be filed within tal Hygiene. d other than "	E C	Elementary/Secondary (0-12) 12th	Conege	(1-4or 5+)		Railr	oad Worke	r		Priva	ite
\mathcal{U}_{i} aryland	be fill	To Be (17. Father's Name (First, Middle Thomas H.	•				18. Mother's Name	ebecca G		10)	
Man	2 m m		19a. Informant's Name/Relation		1			and Number or Rura				
- 'e'	s 1 and f Health Item 27 other tr	-	Barbara Colt 20a. Method of Disposition	er - Daug			sition (Name of natory or other place	e Green D		over, I		.0785 wn, State
COE	Pages nent of int: If It iry or o		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (II Statie			Cem. 3/27			t1and	
Salti	permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service	Ligensee A			. Name and Addre	ss of Facility Stanning Rd.	ewart Fur	neral :	Home	
	Physician		23a. Part Enter the disease, shock, or heart faifure. List Immedia Cause (Finaf disease or condition	or complications that it only one cause on	caused the dea	th. Do not ent	er the mode of dyin	g, such as cardiac c	r respiratory arres			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a. Due to	o (or as a consec	quelo o():	Pin					10 m
	bed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Cue t	Car as a consex	quance of):	i.					10 200
760,		cal Examiner	that initiated events resulting in death) Last	c	O(or as a consec	ence of):	۵					10 1 4
→ × 68.	the death certificat y the attending phy ched for use as the	n/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. ff yes, o	utcome of pregn					23d. Dat	e of delive	ry
)e.	the d ty the ached	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 Feta gnant at time of a nown		Ectopic pregnancy Other (specify)			Ма	nth	Day Year
rds, P	es the	þ	Part II. Other significant condit	ions contributing to	death but not res	sulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba			e cause of death?
Tec.	The law re te has bee age 2 sho	Completed							24a. Was an autopsy performe	dy E	Vere autoportor to content?	osy findings available appletion of cause of
ita/	ician: The certificate ha rector, page	BeC	25. Was case referred to medic examiner?	al				26. Place of Death		3 140	163	20 140
of V	hys his il dii	2	1 Yes 2 No 27. Manny of Death	28a. Date	Inpatient 2 e of Injury onth, Day Year)	ER/Outpatien 28b. Time of Injury	t 3 DOA Othi	4 □ Nursing Hor	ne 5 Residence 28d. Describe how)
Alsion	il or Attending F after death. Director: After 3 in by the funer	Certification;	3 ☐ Suicide 6 ☐ Could	rigation I not be 28e. Plac		nome, farm, stre		Yes 2 □ No	28f. Location (Stree City or Town,	et and Numb	er or Rural	Route Number,
	Hospital or A tours after Funeral Directely filled in by		29a. Certifier 1 ☑ Certify:	ing Physician: To th	ne best of my kno	owledge, death	occurred at the tim	ne, date and place, a	and due to the caus	ea(s) and ma	nner as sta	ated
	o he ele	edical	(Check only 2 Medice	I Examiner: On the and ma	basis of examina nner stated.	ation and/or inv	restigation, in my of	pinion, death occurre	ed at the time, date	and place, a	ind due to	the cause(s)
	To To	Σ	29b. Signature and title of certific		MS		29c. License	2 4 5 3 S	290	Date signed	Z. C	Day, Year)
Q	6		30. Name and address of person	who completed car				Ave., Cl	inton MT	207:	35	
	Stat Registra		31. Date filed (Month, Day, Yeal MAR 2 9 20	32.	Registrar's Sign			nve., UL	incom, ru	, 207.		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** ам Nancy Elizabeth Cozart 03 04 7:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Prince George's Hospital Prince George's Cheverly Birthplece (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, 07/22 **Funeral** Min. 1 ☐ M 2 🖾 F Months Davs Hours 75 577-36-2935 Yrs Director New Jersey Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23s or 28e-f show other treumatic event, the Modical Examinar most be notified at Director Prince George's 1 Yes 2 No Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6475 Pennsylvania Avenue 20747 death v United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Never Married 2 Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ f Yes, Give Year or Dates Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private HouseKeeper 12th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Edna V. Holloway P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John R. Cozart/ Husband 5529 Marlboro Pike Forestville, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Maryland Veterans 3/29/04 Cheltenham, MD ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Rd. Landover, MD 20785 · Marda 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 57/10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit the attending physician and that initiated events resulting in death) Last Due Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🖾 No detached 9 Unknown 9 Unknown ۾ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Pe 1XYes 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has autopsy performe certificate 25 No 1 ☐ Yes Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 1 Inpatient 2 ER/Outpatient 3 DOA this in by the funeral 27. Manner of Death ate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 X Natural death. 1 Tes 2 No 2 Accident Director 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the eq the within 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) ္ 30. N - and address of per on who completed cause of -Item 23a) (Type, Print) 8416 Central Ave. Landover, MD 20785 Ophnell Cumberbatch, M.D. 31. Date filed (Month, Day, Year) State MAR 2 9 2004 Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

			For State	State of	Marylar		artment of H		lental Hygi	ene	S
			Registrar	ant)		Cei	tificate of L	Jeath	Reg	g. No. 2 () (14 1219
	Physici		1. Decedent's Name (First, Middle, La						Month	Day Ye	3. Time of Death
*	/Medic Examin		Willie C. 4a. Fecility Name (If not institution, given	lark, Jr			4b. City. Town, or	Location of Death	Marcn	25,2004 4c. County of D	
	Examili	er	Prince George's					everly			George's
	Funeral	544	5. Social Security Number 6. S	Sex 7	. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)
۲.	Director		226-44-5212	1 ∑ M 2□F	6.5	Yrs.	Months Days	Hours Min.	(Month, Day, 1 June 9,	1938 No	rth Carolina
	w w		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	ty, Town or Lo	cation	<u> </u>			10d. Inside City Limits
	Manyli f sho	ō				,,					1 X Yes 2 □ No
	289-	Director	MD Prince (George's			Hyattsvi 10f. Zip Code	ıııe	100	g. Citizen of Wha	L Country?
	h with	I D	5115 Decatur	St.			207	781		USA	•
	deatl	Funeral	11. Marital Status	12. Was Deced		.S. 13. \	Was Decedent of His f Yes, specify Cubar		ecify Yes or No-	14. Race - A	American Indian,
9	or Ite	y Fu	1 ☐ Never Married 2 Married	1 Tes 2	2 X No		i les, specify cubai I □ Yes 2 X No	Specify:	rican, etc.)	Specify:	Vhite, etc.
Ö	illed within 72 hours after death with the Maryland Hygiene. Vither than "natural", or Iteme 23a or 28e-f show ent, Lie Medical Exarterer inset by rectified at	ed by	3 Widowed 4 Divorced	Year or Da	tes:						Black
5	in 72	Completed	15. Decedent's E (Specify only highest gr	ade completed)		(Give	lent's Usual Occupa kind of work done d DO NOT use retired)	luring most of worki	ng 16	6b. Kind of Busine	ess/Industry
72	with jene r thar	mo	Elementary/Secondary (0-12) 12th	College (1-	4or 5+)		Truck I			Go	vernment
ਰੂ	e filec II Hyg othe	Be C	17. Father's Name (First, Middle, Last	")				18. Mother's Name	(First, Middle, Ma		
Maryland 21215-0036	Menta Menta arkad	ToE	Willie Clar	k, Sr.				Mami	e :	Simmons	
a	2 sho and ls m		19a. Informant's Name/Relationship				g Address (Street a				
	1 and Health em 27 ther to		Alma Laverne Cla	rk/ Wile	20h E	_	Decatur S				781
Baltimore,	ages nt of h		1 ☑ Burial 2 ☐ Cremation 3 ☐		tate C	emetery, cren	natory or other place)		Oc. Location - City	
≣	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or iteme 23a or 28e-f show eny injury or other treumetic event, the Medical Exandrect must be rediffied at once.		4 ☐ Donation 5 ☐ Other (Speci21. Signature of Funeral Service Lice		1 1		vet Cemet			Washingt	
ä	Depar Impo eny ir		+ L. D. Ma	what			74 Landov				
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ca	used the deat	h. Do not ente	er the mode of dying	, such as cardiac o	r respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			al Card	liac Arryt	hmia			Onset and Death
A	/Medical Examiner		resulting in death)	Due to (o	r as a conseq	uence of);					50 mins
	LAdiminei	<u>.</u>	Sequentially list conditions.	b							
	ted	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to to	r as a conseq	uence or):					
	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (o	r as a conseq	uence of);					
8760,	ysicia ysicia	dlcal		d							
9	ntifica ng ph as th	Jedl	IF FEMALE:								
Вох	eath certific attending p for use as	by Physiclan/Me	23b. Was decedent pregnant in the past 12 months?		th 2 Feta	I death 3 🗌	Ectopic pregnancy			23d. Date of	
0	the a	ysic	1 Yes 2 No 9 Unknown	4□Pregna 9□Unknov	nt at time of de vn	eath 5□	Other (specify)	· · · · · · · · · · · · · · · · · · ·		Month	Day Year
٥.	that the de ed by the a detached t	/ Ph	Part II. Other significant conditions	contributing to dea	th but not res	ulting in the un	iderlying cause give	n in Part I.	23e. Did tobac	cco use contribute	e to the cause of death?
Records,	w requires that been signed should be det	d b	Hypertension				, , ,		1 ☐ Yes	2 □ No 3 □	Probably 4 Zunknown
<u>o</u>	s bee	Completed	Pulmonary Hyper	tension					24a. Was an	24b. Were	autopsy findings available
Re	The lay	шо							autopsy performe 1 ☐ Yes 2 ☑	d? death	
Vita		Be C	25. Was case referred to medical examiner?					26. Place of Death		2140	92 27 140
	Physic this ce	ို	1 ☐ Yes 2 ☐ No			ER/Outpatient		4 Nursing Hon	ne 5 🗆 Residend	ce 6 Other (S	(pecify)
Division of	ding P. h. After I	ion:	27. Manner of Death 1 Natural 5 Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	28c. Injury Work		8d. Describe how	injury occurred	
<u>s</u>	f or Attendiater death Director: A	icat	2 Accident investigatio 3 Suicide 6 Could not b		f Injury - At he	ome farm stre		es 2 □No	Rf Location (Street	at and Number or	Rural Route Number,
2	or A	Certification:	4 ☐ Homicide determined	building	g, etc. (Specify	()	et, factory, office		City or Town, S	State)	nulai noute Nullioei,
	To the Hospitel within 24 hours and to the Funerel completely filled		29a. Certifier 1 X Certifying Pt	nysician: To the b	est of my kno	wledge, death	occurred at the time	e, date and place, a	nd due to the caus	se(s) and manner	as stated.
	the H hin 24 the Fi	Medical	0.16)	and manne	er stated.	tion and/or inv	estigation, in my opi				
	or with the contract of the co	2	29b. Signature and title of certifier	Z_{Δ}	0	MA	29c. License		1	. Date signed (Mo	- 10 -
	(m)		2000 C	47 CMO	juo e	11		31080		03/2	0104
	0		30. Name and address of person who Dr. Silvia Picca				^{Print)} ennsylvani	ia Ave. N	.W. Wash	nington.	DC 20037
	Sta	te	31. Date filed (Month, Day, Year)	32. Rec	gistrar's Signa		- J - ·			J ,	
	Registr	ar	MAR 2 9 2004	Bleek	J. J.K	Aport	D .				
Ditt		01		-		•					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar/AMEND#19bper/FH4/5/04, BMW, McCo Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year Physician Carl James 5:45 Cali 29 2004 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3500 Forest Edge Drive, Apt. 1B Montgomery Silver Spring 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Months Hours Min 152 M 2□F 579-18-8363 Yrs. Director July 31, 1922 Washington, DC Usual Residence of Decedent the Maryland to or 28e-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 TYes 2 No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with ir then "neturel", or Items 23s. The Modical Examiner must t 3500 Forest Edge Drive, Apt. 1B 20906 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☑Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: WWII þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4or 5+) 12 Cartographer Travel Association treumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be finent of Health and Mental Isont: If item 27 is marked of Salvatore Cali Angelina Bucca 19a. Informant's Name/Relationship (Type, Print) f Health item 27 Virginia M. Cali/ Wife Forest Edge Dr., Apt. 1B, Silver Spring, MD 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of April 1, 20c. Location - City or Town, State Gate of Heaven permit. Pages
Department of I
Importent: If it
eny injury o 1 Burial 2 □ Cremation 3 □ Removal from State Cemetery 2004 * 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee hneMarie 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Idiopathic Pulmonary Fibrosis 2 Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Physiclan/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records. 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Coronary Artery Disease, Hypertension, Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Diabetes Mellitus- Type II page 2 2□ No 1 ☐ Yes 2 🔯 No 1 Yes Hospital or Attending Physicien: in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 1 ☐ Yes 2 🗵 No 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After Division 1 X Natural 5 Pending after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, streel, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ç D23958 March 29, 2004

DHMH 17 Rev 1/2001

State Registrar 3305 N. Leisure World Blvd., Silver Spring, MD 20906

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pegistrar's Signature

Burt I. Feldman M.D.

31. Date filed (Month, Day, Year) MAR 3 0 2004

			State of Maryland / Departs		ental Hygie	ne	
		_	1 - State Certif	ficate of Death	Reg.	No. 2004	12199
Н	Physici	an	Decedent's Name (First, Middle, Last) JUAN A CANALES		Month	Day Yeer 2004	4:50 P ^M
7	/Medic			b. City, Town, or Location of Death	IIIICII Z	4c. County of Deeth	1 = . 30 1
1	LXdiiiii	C.	Washington Adventist Hospital	Takoma Park		MONTGOM	
	Funeral			f Under 1 Year If Under 24 Hrs. Ionths Days Hours Min.	8. Date of Birth (Month, Dev. Ye Nov. 10,	9. Birth:	plece (State or Foreign http) Lerto Rico
	Director		Usuel Residence of Decedent		1400.10,		
	uyland show		10a. State 10b. County 10c. City, Town or Locati MD Prince Geo. Laure			1	10d. Inside City Limits 1 ☐ Yes 🏖 No
	Ne Ma	Director	10e, Street and Number	EI 10f. Zip Code	100	. Citizen of What Cour	
	with I			20708		U.S.A.	
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces?	s Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	or ite	by Fu	1 Never Married Married 1 Married 1 Married 3 Wes, Give 1 Married 3 Widowed 4 Divorced 1 Married	Yes 2□ No Specify: Pue	rto	Specify: B	lack
9	within 72 hours after death with the Maryland ene. than "netural", or items 23e or 28e-f show ta Medical Exercities transite notified at	ted b	15. Decedent's Education 16a. Decedent	Ric	168	b. Kind of Business/In	dustry
215	ithin 7 ie. ian "n i.Medi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cus	d of work done during most of workir NOT use retired)	_	rince Ge	
72	filed w Hygier other th			todian 18. Mother's Name		ublic Sc	nools
au	lid be ked o	To Be	T 1 1 D A 1	Cons	uelo Ga	rcia	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. Item 27 is marked other than "netural", or items 23a or 28e-f show other traumatic event, tra Medical Exercitive frank La notified at		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	Address (Street and Number or Rura			
dî.	1 and Health em 27		Gloria Canales (Daughter) 8711 20a. Method of Disposition 20b. Place of Disposition camelery, cremate	Plymouth St.,	•	LIVER SUR C. Location - City or To	
Jou	ages ont of tr. If it		1 🔀 Burial) 2 □ Cremation 3 □ Removal from State '4 □ Donytion 5 □ Other (Specify) MD Veter			rownsvil	
Baltimore,	permit. Pages 1 Department of Importent: If its any injury or ot		21. Signature of Fundal Service Licentee 22. No	ame and Address of Facility SNC	WDEN FU	NERAL HO	ME, P.A.
8	89 2 2 3			6 N. Wash. St.			
	Di Chiana		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the shock, or hearfailure. List only one cause on each line. Immediate Cause (Final				Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	SHOCK.	0		12/445
B	Examiner		Sequentially list conditions, b. THOM BOSED M	SHOCK. LITTEAL VALUE 1	Pasmes	15	DAYS
	pet usit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evenits b. The Due to (or as a consequence of): C. LNADEQUATE	ANTICOAGU	117704	1	DAYS-WEEK
ó	ate be executed nysician and he burial-transit		resulting in death) Last Due to (or as a consequence of):	Noncondu	LATION		
8760,	ate be physicia the bu	dical			· · · · · · · · · · · · · · · · · · ·		
89 x	eath certificat attending phy for use as th	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant			23d. Date of delive	ery
. Box	the death certifical y the attending phy ached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 1 Yes 2 No 1 No	topic pregnancy ther (specify)	···	Month	Day Year
P.0	that the death ed by the atte detached for	Phys	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the under	arking cause given in Part I	23e. Did tohac	co use contribute to the	he cause of death?
ds,	Se ig	Completed by	SALVAGE REDO MITRAL VALUE	REPLAKEMENT		2□No 3□Prot	
Records,	aw requii ts been s 2 should	olete		,	24a. Was an	24b. Were auto	opsy findings available impletion of cause of
I Re		Com			autopsy performed 1 Yes 2	d? death?	2 No
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death			
of	g Phys er this eral di	n: To		3 DOA 4 Nursing Hon	ne 5 Hesideno 28d. Describe how i	e 6 Other (Specifinjury occurred	у)
sion	ending eath. or: Aft	atio		M 1 Yes 2 No			
Division	al or Attending P s after death. I Director: After d in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	, factory, office 2	28f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
_	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.			ocurred at the time, date and place, a	and due to the caus	e(s) and manner as s	tated.
	To the H within 24 To the Fi complete	Medical	one) and manner stated. 29b. Signature and title of certifier	200 Linears sumber	204	Data signed (Month	Dou Year)
	7 ¥ ± 0		Dom drie MD	036207	N	LARCH 25	,2004
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print	nt)		D	1.0-01.0
	C+	ate	DR- THOMAS C. M. ITANO 76010 31. Date filed (Month, Day, Year) 32. Begistrar's Signature	D36207 CARROLL Ave,	IAKON	A LANK, N	1020412
	Regist		MAR 29 2004	aparkal			

	1 - For State Registrar	State of Maryland / Dep	eartment of Health and Nertificate of Death	nental Hygiene Reg. №	2001 1000
Physician	1. Decedent's Name (First, Middle, Las			2. Date of Death Month Day March 29,	
/Medical Examiner	4a. Facility Name (If not institution, give Suburban Hosp	street and number) ital	4b. City, Town, or Location of Death Bethesda	40.	County of Death Montgomery
Funeral Director	294-14-6634	7. Age (In yrs. last birthday M 2፟□ F 79 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) July 13, 19	
Maryland a-f ehow	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome	10c. City, Town or Lery Rockvi			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the	10e. Street and Number 199 Rollins Avenu	#/21	10f. Zip Code 20852	10g. Cit	izen of What Country?
0036 hours after death with the Maryland lural; or Itama 23e or 28e-f show at Exercipation of the Funeral Director			Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 \(\text{Yes} \) 2 \(\frac{16}{25} \) No \(\text{Specify:} \)	pecify Yes or No- Prican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: White
10 0 m 11 12	15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12)	de completed) (Giv life.	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) anager	Mon	ind of Business/Industry atgomery Ward's
Baltimore, Maryland 21215 permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other then " any injury or other traumatic event, the Mana	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Maiden Helen May S	Sumame)
Mary	19a. Informant's Name/Relationship (7) Charles Edward C		ing Address (Street and Number or Rur 9 Rollins Avenue		
Pages 1 an ment of Hea	20a. Method of Disposition 1 ☐ Burial 2 ဩ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from State 20b. Place of Disp	osition (Name of ematory or other place) Marc	Date 20c. Lo	cation - City or Town, State
Balti permit. Departi Importe any inji	21. Signature of Funeral Service Licen	F Byl F	22. Name and Address of Facility rancis J. Collins OO University Blvd	Funeral Hom	ne Inc. er Spring, MD 20901
Physician /Medical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. HEPATIC Due to (or as a consequence of): b. SEPSIS	CIRRHOSIS	ог гозриацогу атгозт,	Approximate Interval Between Onset and Death
8760, sale be executed bhysician and the burial-transit dical Examiner		Due to (or as a consequence of): C. Due to (or as a consequence of): d.			
P.O. Box 6876 that the death certificate be by the attending physicis detached for use as the but Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown/		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
to se and se	artii. Other significant conditions co	ontributing to death but not resulting in the	underlying cause given in Part I.	_ \	ise contribute to the cause of death?
The The page				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
→○★ 東 温息 H	examiner?	Hospital: Inpatient 2 ER/Outpatie	ont 3 DOA Other: 4 Nursing Ho	h (Check only one)	
Hone After	27. Manner of Death Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injur 28f. Location (Street an)	y occurred d Number or Rural Route Number,
Division Division Division To the Hospital or Attent Within 24 hours after death To the Funeral Director: completely filled in by the	4 Homicide determined	building, etc. (Specify)		City or Town, State,)
the Hospital thin 24 hours is the Eunaral Impletely filled Medical Co	(Check only one)	ysician: To the best of my knowledge, dea liner: On the basis of examination and/or ii and manner stated.	nvestigation, in my opinion, death occuri	red at the time, date and	place, and due to the cause(s)
Mithin Common	29b. Signature and title of certifier Alperal	promon MD	29c. License number D-27660		e signed <i>(Month, Dey, Year)</i> rch 30, 2004
,	30. Name and address of person who of	empleted cause of death (Item 23a) (Type	ROCKUILLE PIL	E, Roc	12011E
State Registrar	MIND 0 1 00/	32. Registrar's Signature	South	J. Cl.,	See V

			For State Registrar	State of Marylar	nd / Depa	artment of H	ealth and	Mental Hy		+ 12201
	Physici /Medic	al	Decedent's Name (First, Middle, Last HARRY ELLWOOD As. Facility Name (If not institution, give	CLARK, Jr.		4b. City, Town, or	Location of Deat	2. Date of De. Month APRIL	Day Year 6 200	
	Examir 	ier	RAYLAND ACRES 5. Social Security Number 6. Se	x 7. Age (In yrs.	last birthday)	TRAP			TALBO'	
*.	Director		215-38-1801 Usual Residence of Decedent 10a. State 10b. County	M 2□F 89	Yrs. ty, Town or Lo		TIOU'S WIII.	JULY 8	1914 MA	RYLAND 10d. Inside City Limits
	ith the Mary or 28a-f sh	Director	MD TALE	TO	EASTO	N 10f. Zip Code			10g. Citizen of What C	1 ☐ Yes 2 No ountry?
36	within 72 hours after death with the Maryland ane. than "natural", or Itams 23e or 28e-f show is Medical Exerciter musiles rostified at	by Funeral I	27843 WAVERLY RO	12. Was Decedent Ever in U Armed Forces? 1 Twes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes ※ No	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)		
21215-0036	be filed within 72 hours aft ital Hygiene. id other than "natural, or event, it a Medical Exerci-	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ication	(Give life. I	dent's Usual Occupa kind of work done o DO NOT use retired	turing most of wor	rking	16b. Kind of Business	Andustry
Maryland	should be filed within and Mental Hygiene. I marked other than umatic event, it a Mi	To Be C	17. Father's Name (First, Middle, Last) HARRY E. CLARK SE		49, 11, 11		LYNNE S	SHIELD	Maiden Sumame)	
	Health ar Health ar tem 27 is		19a. Informant's Name/Relationship (T) H. STEVENS CLARK/ 20a. Method of Disposition	SON 20b. F	314 Place of Dispo	10 MILLER sition (Name of	ROAD, C		or, City or Town, State, MD 21625 20c. Location - City or	
Baltimore,	permit. Pages Department of Important: If it any injury or o		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funer Service License	SPR	ING HI	natory or other place LL CEMETE . Name and Addres	RY 4-13	3-2004	EASTON, M	
	N. S.		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ne cause on each line.	th. Do not ent	00 S. HAR	RISON ST	' BASTON.	NAM FUNERAL, MD 21601 rest.	Approximate Interval Between Onset and Death
760,	Physician	ical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect of the conse	quence of): quence of):					years
.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn. 1□ Live birth 2□ Feta 4□ Pregnant at time of c	uldeath 3□	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
Records, P.	requires seen sign hould be	b	Part II. Other significant conditions co	ntributing to death but not res	sulting in the ur	nderlying cause give	on in Part I.	1 🗆 Y	obacco use contribute to	robably 4 Unknown
Vital Rec	sician: The law scertificate has birector, page 2 s	e Completed	25. Was case reterred to medical				26 Place of Dea		prior to death? No 1 Yes	utopsy findings available completion of cause of
of Vi	Physician: this certific ral director,	To B	TE TOS SENO		ER/Outpatien		or: 4 🗆 Nursing H	lome 5 Resid	lence 6 XOther (Spe	ASSISTED LIVING
Division of	ling After Tune	Certification:	27. Manner of Death Natural 5 Pending investigation 3 Suicide 4 Homicide Homicide	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h building, etc. (Specil	28b. Time of Injury ome, farm, str		at ?? ∕es 2 □No		ow injury occurred Street and Number or Ri n, State)	
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the t	Medical C	29a. Certifier Check only one) Certifying Phy 2 Medical Exam	sician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death	occurred at the time restigation, in my op	e, date and place pinion, death occu	, and due to the or	cause(s) and manner as date and place, and due	s stated. to the cause(s)
	To the within To the comp	Ž	29b. Signature and title of certifier	M		29c. License	25937	3	29d. Date signed (Mont	
	Sta	at <u>e</u>	30. Name and address of person who c MICHAEL D. CROWI 31. Date filed (Month, Day, Year)		IDLEWI	Print) LD AVE EA	STON, MD	21601		
DH	Regist		APR 0 7 2004	Som B	ORIGINA	S				

HARRY ELLWOOD CLARK

			1 - For State Registrar		aryland / De	partmer ertifica			d Mental H	ygiene Rag. No.	2004	12202
	Physic /Medi		1. Decedent's Name (First, Middle, L Alice Wilkinso	n Cook					2. Date of I	5 ^{Day}	2 0 0 ^Y 4ar	3. Time of Death 5:30 a M
<i>}</i>	Examir	ner	4a. Facility Name (If not institution, g. William Hill M. 5. Social Security Number 6.	lanor		Eas	, Town, or ston er 1 Year	Location of De		Та	ounty of Death	(2)
	Funeral Director				ge (In yrs. last birthd 88 Yrs	Months			07-1	Birth Day, Year) 7 – 191	5 Bal	place (State or Foreign Try) Cimore, MI
	a-f show	ctor	MD 10b. County Talbot	-	10c. City, Town or Easton	Location					1	I0d. Inside City Limits X□Yes 2□No
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 545 Cynwood I	or.			p Code 1 6 0 1			_	n of What Cour SA	ntry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show may injury or other traumatic event, the Medical Examinat must be nutified at ance.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ██Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	?	3. Was Dece If Yes, spe 1 \(\subseteq Yes	ecify Cuba	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or I lerto Rican, etc.)		Race - Americ Black, White, pecif Whit	etc.
21215-0036	within 72 hc iene. 'than "natur I'e Medical	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 11 years	Education rade completed) College (1-4or 2 years	5+) (G	ocedent's Usu ive kind of wo e. DO NOT u	ork done d ise retired	ation lu <i>ring most of</i> (working	16b. Kind	of Business/Ind	dustry
	al Hygi I other	Be C	17. Father's Name (First, Middle, Las	(t)		Jinema.	ICI		Name (First, Mido	le, Maiden Su	ımame)	
Maryland	nould by Ment	To Be	Walter Scott V 19a. Informant's Name/Relationship			- iliaa Addaa	- (Ctu- et -		e Virg			0.40
	nd 2 sl alth an 27 Is r r traur		Alice Penny R						Rural Route Num			
Baltimore,	Pages 1 and neut of Hearn ant: If itam		20a. Method of Disposition 1 Burial 2 □ Cremation 3 1 □ Donation 5 □ Other (Spec		20b. Place of Dis Maple of Dis	sposition (Na Hematory or (me of ether place ether place	tery 4	Date 1-8-200	20c. Loca 4 Cla	tion - City or To iborne	own, State . , MD .
Balt	permit. Departr Imports any inj		21. Signature of Funeral Service Lice	Istruly	C 7.5.1	2.0.	Box	518, St	ley Fun .Micha	els,M		
	Physician and Asician and Paritansit partial-transit	Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List onli Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of): a consequence of):	Muq	de of dying	g, such as card	liac or respiratory	arrest,		Approximate Interval Between Onset and Death
P.O. Box 68760,	eath certifica attending ph for use as th	Completed by Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d	2 Fetal death	3 □Ectopic p 5 □ Other (s)				230	d. Date of delive	ory Day Year
Records, P.	w requires that the de been signed by the a should be detached	ted by Pr	Part II. Other significant conditions	contributing to death b	out not resulting in the	punderlying o	cause give	n in Part I.	1/2 1	tobacco use		e cause of death? ably 4 ∐Unknown
_	The lay ate has page 2					,			24a. We aut per	opsy formed?	prior to con death?	psy findings available inpletion of cause of
. Vit	ysicial is certii directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	ent 2 ER/Outpai	tient 3 D	OA Othe		eath <i>(Check only</i> Home 5 Re		Other (Specify	1)
Division of Vital	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation		ıry 28b. Time ıy Year) Injur	of 2 y M	28c. Injury Work 1 🔲 Y		28d. Describe			,
Divis	ital or Atti rs after de ral Diracto led in by t	Certification;	3 ☐ Suicide 6 ☐ Could not determine	1 28e. Place of in	jury - At home, farm, ic. <i>(Specify)</i>	street, factor	y, office		28f. Location City or T	(Street and Nown, State)	lumber or Rurai	l Route Number,
	tha Hospi in 24 hou tha Funar	Medical	(Check only 2 Medical Exe	thysician: To the best miner: On the basis o and manner st	f examination and/or	investigation	i, in my op	inion, death oc	ce, and due to the	, date and pla	ace, and due to	the cause(s)
	with con	2	29b. Signature and title of certifier	ta Ul	mo	29	c. License	352	84	41	igned (Month, L 5/04	
			30. Name and address of person who	completed cause of a	meath (Item 23a) (Type	pe, Print)	50	wa sh	ingto	4 ST	+ Bus	Kn mo
	Sta Regist		31. Date filed (Month Day, (Jean)	004 Registr	ar's Signature	and !			V	_		21601

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 0733 Crabtree, Evans Leroy Sr. MARCH 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth (Month, Day, Year) 429 Wyoming Ave. Hagerstown Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1X M 2□ F Maryland 71 220-28-4181 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County . Hygiene. other than "natural", or Itama 23e or 28e-f show rent, the Mudical Exeminan he notified at 1 XYes 2 ☐ No Director Washington MD Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 429 Wyoming Ave. U.S.A. 21740 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltege (1-4or 5+) Shipping/Receiving Porter Chemical Co. of Health and Mental Hygis Item 27 Is marked other rother traumatic svent, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental William W. Crabtree Margaret C. Gillam 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine L. Crabtree/Wife 429 Wyoming Ave. Hagerstown. MD 21740 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) = 5 Department o Important: If any injury or once. Smithsburg Crematory 3/23/2004 Smithsburg MD 22. Name and Address of Facility Rest Haven funeral Chapel 21. Signature of Funeral Service Licensee permit. Shiphon 1601 Pennsylvania Ave. Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) month, Physician Mancho? /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the first line in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physician the buria Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 ☐ Unknown څ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has birector, page 2 s 1□ Yes 2 🗹 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? uneral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I 29a, Certifier 1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2145 DIX 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OAKHIK AVE. HAGERSTOWN MO BOUL 2821 WATERD, MD-31. Date filed (Month Aan Year) 3 32. Registrar's Signature State Registrar

				artment of Health and M rtificate of Death	Reg.	ne . No. 2004	12204
	Physici		Decedent's Name (First, Middle, Last) MARY VIRGINIA CRONISE		2. Date of Death Month March	Day 19, 2004	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number) REEDERS MEMORIAL HOME	4b. City, Town, or Location of Death BOONSBORO		4c. County of Death WASH	INGTON
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 215-34-3746 1 M 2 F 82 Yrs.	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, You JUNE 5,	9. Birth 1921	place (State or Foreign ntry) MARYLAND
	72 hours after death with the Maryland Ineturel', or Items 23e or 28e-f show Digal Examiner was be nutified at	ctor	10a. State 10b. County 10c. City, Town or L MARYLAND WASHINGTON	BOONSBORO			10d. Inside City Limits 1 XYes 2 □ No
036		by Funeral Director	10e. Street and Number 141 S. MAIN STREET 11. Marital Status 1 Never Married 2 Married 1 Narried 1 Narried 2 Married 1 Narried 2 Married 1 Narried 1 Narr	10f. Zip Code 21713 Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F		Citizen of What Cou U 14. Race - Amen Black, White, Specify:	S.A.
121215-0036	be filed within 72 ha ital Hygiene. id other then "netui event, It e Maulcal	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of workin DO NOT use retired) COSMETOLOGIST 18. Mother's Name	OW.	NER OF BEA	<u> </u>
Maryland	Q 2 2 9	To Be	ORVILLE TAYLOR	EFFIE SC		oen surname)	
-	ges 1 and 2 sh t of Health and If item 27 is m or other treum		PATRICIA L. EASTERDAY/DAUGHTER 5726 20a. Method of Disposition Was Burial 2 Cremation 3 Removal from State	matory or other place)	H ROAD, B	OONSBORO, c. Location - City or To	MD 21713 own, State
Baltimore,	permit. Pag Department Importent: I any injury o			RO CEMETERY 3/23/ 2. Name and Address of Facility BAST FUNERAL HOME	7606 OL	OONSBORO. D NATIONAL RO. MARYLA	PIKE
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a.		r respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of): Sequentially list conditions b. Congestive	Heart failure			years
	te be executed ysician and te burial-transit	Examiner	Sequentially list conditions, and the sequence of the sequence	Heart failure Insis			Years
8760,	icate be e physiciar s the buris		a Athrosell	LISSES			Years.
P.O. Box 6	t the death certific by the attending p ached for use as	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
	w requires that the been signed by should be detact	by	Part II. Other significant conditions contributing to death but not resulting in the use of the significant conditions contributing to death but not resulting in the use of the significant conditions contributing to death but not resulting in the use of the significant conditions contributing to death but not resulting in the use of the significant conditions contributing to death but not resulting in the use of the significant conditions contributing to death but not resulting in the use of the significant conditions contributing to death but not resulting in the use of the significant conditions contributing to death but not resulting in the use of the significant conditions contributing to death but not resulting in the use of the significant conditions contributing to death but not resulting in the use of the significant conditions contributing to death but not resulting in the use of the significant conditions contributing to death but not resulting in the use of the significant conditions contributed to the significant conditions conditions contributed to the significant conditions contributed to th	inderlying cause given in Part I.	23e. Did tobace	co use contribute to the	ne cause of death? pably 4 ⊡Unknown
Vital Records,	: The law re cate has bee page 2 sho	Completed	Seni/1lg		24a. Was an autopsy performed 1 Yes 2	1? death?	psy findings available mpletion of cause of 2 No
ō	Attending Physicien: The law requires that the death certificate be executed rideath. cleath. ector: Atter this certificate has been signed by the attending physician and be the funeral director, page 2 should be detached for use as the burial-transit	atlon: To Be	25. Was case referred to medical examiner? 1			e 6 □Other (Specifinium)	y)
Division	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely tilled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 2	8f. Location (Street City or Town, St	t and Number or Rura tate)	l Route Number,
	ne Hospi ne Funer detely till	65	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, at vestigation, in my opinion, death occurre	nd due to the cause d at the time, date	e(s) and manner as si and place, and due to	ated. the cause(s)
	To th withir To th	Me	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier W.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, 2004) 31. Date filed (Month May 1) (1992) (2004) 32. Registrar's Signature	29c. License number D 44996	29d.	Date signed (Month, MCL 19,	2004
1	*3		30. Name and address of person who completed cause of death (Item 23a) (Type, 29+97 M9/IK MD 203//	Cappans Rd Bu	onsboro	MO 21	713
ļ	Sta Registr	ite ar	31. Date filed (Month A) (Yea) 2 2004 32. Registrar's Signature	park			

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month o Dayth Year **Physician** April CASSETTA HEN RY 2004 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ruxton Health & Rehabilitation Ctr. Pikesville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Jul. | 17, 1943 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 60 Yrs. **Director** 218-40-2527 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at MD Randallstown 1 ☐ Yes 2X No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itame 23s or 4207 Deer Park Road 21133 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1960-Baltimore, Maryland 21215-0036 ŏ White 1 ☐ Yes 2 No ğ 1964 3 Widowed 4 Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contractor Home Construction 12 .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie 1ant: if item 27 is marked other t jury or other traumatic event, IL other t7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henry Cassetta Mary Sue Howell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Sue Clark/Mother 717 Maiden Choice Lane, St. 210, Catonsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Apr. 6, permit. Page Department o Important: if eny injury or once. Metro Crematory 1 4 □ Donation 3 □ Other (Specify) Baltimore, MD 2004 21. Signature of Funeral Ferrice Licensee Barranco & Sons, 495 Gov. Ritchie P.A. Severna Park Funeral Home Hwy, Severna Park, MD 21146 rt1. E for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or learn failure. Ust only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final disease or condition resulting in duath) INOSEPSIS Physician /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ENEBROURSCULTA 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? HEMIPAREISIS ACCIDENT! WITH 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this s after death.
I Director: After this
of in by the funeral d 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours aff To the Funeral Di comi-letely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of pers who completed cause of death (Item 23a) (Type, Print) 5705 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State APR 09 2004 Registrar

Amend Item#19a per Fun. Dir.
State of Maryland / Department of Health and Mental Hygiene 2001 For 2/27/04 BEM State of State of Registrar AACo. Health Dept. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Ida Louise Davis February 2004 7:25P /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ft. Washington Prince Georges Ft. Washington Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🔀 F 217-34-0778 68 1935 Maryland Director \$ept 20 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County r then "natural", or Itams 23a or 28a-f ehow the Medical Examiner must be notified at 1X Yes 2 □ No Maryland Anne Arundel Lothian Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1281 Mt. Zion Marlboro Rd. 20711 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status within 72 hours after 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 20 Married 1 ☐ Yes 2 ▼ No Specify: Specify: Black δ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) P.G. Co. Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Court House Custodian 11th of Health and Mental Hygie if Item 27 Is marked other in other traumatic event. other filed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 90 Arthur E. Smith Emma Mullen Pages 1 and 2 should (Husban 1) 6. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 81 Mt. Zion Marlboro Rd. Lothian. Md 19a. Informant's Name/Relationship (Type, Print)
Thomas, L. Davis Jr. nt of Health a t: if item 27 la y or other tra Zion Marlboro Rd. Lothian, Md. 20711 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other place)
Moses Cemetery 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or 2-28-04 Drury, Md. * 4 ☐ Donation 5 ☐ Other (Specify) permit. Wm. Reese & Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee Lavy A, Deese MO048 821 West St. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) di **Physician** Ne wone /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Carchonia physician and the burial-transit death certificate be executed und 0 Physician/Medical as 1 attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown The law requires that the 9 Unknown s been signed by t should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 r this certificate has 2[®]No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1924-Inpatient 2 ER/Outpatient 3 DOA Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{Specity} \) 1 Yes 2 No 2 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0045046 2-23-200 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 11711 Livingston Rd. Fort Washington, Md. 20744 Alikhani 32. Rg 31. Date filed (Month, Day, Year) strar's Signature State FEB 2 7 2004

DHMH 17 Rev 1/2001

Registrar

Maryland 21215-0036

altimore.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar perM.D., TCHD, 03/03/04, sbb Amended, #30, Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day DIAMOND SR. JOSEPH MARCH 26, 2004 1107 AMM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 109 SOUTH PARK STREET EASTON TALBOT 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12-01-1922 **Funeral** 9. Birthplece (State or Foreign **₩** M 2 🗆 F Director 183-16-7880 81 PEŇŇŠÝLVANIA Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location ir than "natural", or items 23e or 28a-f show the Medical Exandrer must be notified at 10d. Inside City Limits Director Yos 2 No TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 SOUTH PARK STREET 21601 U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces? NAVY 1X Yes 2 No 1942-45 Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. tiled within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: WHITE þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 0 MEAT CUTTER GROCERY STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be nd Mental I Pages 1 and 2 should be EDWARD JOSEPH DIAMOND 2 MARGUERITE LENNON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health at Hitem 27 is 474 EDGEWATER RD PASADENA, MD 21122 MARGARET C. DIAMOND/DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State or Department Important: eny injury c ' 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEMETERY 3-30-2004 HURLOCK, MARYLAND 21. Signature of Funeral Service Licensee 22 FELECUS; SHEEFENBEIN & NEWNAM FUNERAL HOME P.A. Joseph M. Ostrowski 200 S. HARRISON ST. EASTON, MD. 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIOVASCULAR ACCIDENT MINUTES /Medical Due to (or as a consequence of): Examiner ATRIAL FIBRILATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner -transit certificate be executed CORONARY ARTERY and burial physician Box 68760 Physician/Medical HYPERTENSION the t as the attending IF FEMALE 951 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ğ in the past 12 months? Month 5 Other (specify) P.0. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ HYPERCHOLESTROLEMIA Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan certificate has page of Vital 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 TResidence 6 Other (Specify) 1 ☐ Yes 2 👺 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of Atter 28d. Describe how injury occurred Division or Attanding Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0052255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5463 Muhammad EJAZ M.D DUNFRIES COE erra. 830 Chesa Peake 31. Date filed (Month, Day, Year) 32. Registrar's Signature

ORIGINAL

410-228-6243

DHMH 17 Rev 1/2001

Registrar

		Please 1 1 - State Registrar	State of Mary	rland / Depa		lealth and	Mental Hy	giene	2004	12208
Physic /Med	lical	1. Decedent's Name (First, Middle, Last, John Everett Du			Ab City Town o	r Location of Dea	2. Date of Dea Month March) as	Year Ownty of Death	3. Time of Death 0850 AM
Exam		5. Social Security Number 6. Sec	ital at E	adon yrs. last birthday)	EastC If Under 1 Year		s. 8. Date of Birt	To	ribot	place (State or Foreign
Director		Usual Residence of Decedent	M 2□F 94	Yrs.		Hours Min	5-12-	1909	Roy	ral Oak, MD
ith the Marylan or 28a-f show	ector	MD Talbot		st. Mich	aels			10g Citize	en of What Cou	1 2 Yes 2 No
after death w	by Funeral Director	100. Street and Number 1006 Riverview 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	Terrace 12. Was Decedent Eve Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	r in U.S. 13.	10f. Zip Code 21663 Was Decedent of It if Yes, specify Cub 1 ☐ Yes 2 ☐ ₩o			. U	SA 4. Race - Ameri Black, White, Specify: Whi	can Indian, etc.
C	ompieted	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup e kind of work done DO NOT use retire	during most of wo	_		d of Business/In Michae	Co. els Millin
Tand < 1 < 1 < 1 < 1 < 1 < 1 < 1 < 1 < 1 <	To Be C	6 years 17. Father's Name (First, Middle, Last) Harry Edmundson	Dulin				ame (First, Middle,		iumame)	
Pages 1 and 2 should ent of Health and Men nt: If Item 27 is marke ry or other traumatic		19a. Informant's Name/Relationship (7) Julia D. Pace (20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	_{гре, Print)} daughter)	1006 20b. Place of Disposemetery, cre	matory or other pla	and Number or R	Crace, Date	St.M 20c. Loca	ichael ation - City or To	S, MD. 2166 own, State
permit. Page Department important: flangury o	a line	21. Signature of Funeral Service Licens	ee 16. 1.	P R	n Memor Name and Addre Carro	ess of Facility	Ley Fund	eral	Home,	PC.
Physiciar /Medica Examine	il	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	Due to (or as a c	stole onsequence of):	iter the mode of offi	1 . 1.	action	riest, D , I	MU.210	roximate Interval Between Onset and Death Minutes Minutes
. BOX 08/0U, death certificate be executed e attending physician and id for use as the burial-transit	ca	resulting in death) Last	Due to (or as a c	pregnancy				23	3d. Date of deliv	rery
* 0 00	Physician/Medi	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 □ Live birth 2 [4 □ Pregnant at tim 9 □ Unknown		□Ectopic pregnand □ Other (specify) _	у			Month	Day Year
vequires that the deben signed by the	þ	Part II. Other significant conditions co	1	not resulting in the	underlying cause gr	ven in Part I.	1	obacco us Yes 2 🗆		the cause of death?
II KECOTGS, F.O. The law requires that the rate has been signed by the page 2 should be detached.	Completed		<u> </u>				24a. Was autop perfo 1 \(\text{Yes}	med?	24b. Were auto prior to co death? 1 \(\sum \text{Yes}	opsy findings available ompletion of cause of 2 No
r VITAL Prysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Un mais als		100		eath (Check only o	ne)		
on of ding Phys	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatie 28b. Time (Injury	of 28c. Inju	ry at	Home 5 Resident Resid			fy)
DIVISION O' To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28f. Location (. City or To		Number or Run	al Route Number,				
Lothe Hospital within 24 hours a Tothe Funeral I completely filled	edical (rsician: To the best of r iner: On the basis of ex and manner state	amination and/or i						
To the within To the comp	We	29b. Signature and title of certifier	aidyana	than M		se number 0577 (1 ^-		signed (Month,	Day, Year) 12004
		30. Name and address of person who o								
	State strar	Lakshmi Vaidyan. 31. Date filed (Month, Day, Year) MAD 2.9 200	athan MD 32. Registrars	Signature S.	Washin•	gton St	. Eastc	n,MD	21601	<u> </u>

DHMH 17 Rev 1/2001

ORIGINAL

For State Registrar			ck Indelible Ink. Ensure Al Department of Health and M Certificate of Death	-	ygi	_		12209
1. Decedent's Name (First	st, Middle, Last)			2. Date of D Month	eath	Day	Year	3. Time of Death
Minerva	R.	Dorris		April	7,	2004		10:30 P M
4a. Facility Name (If not i	institution, give street an	d number)	4b. City, Town, or Location of Death			4c. County	of Death	

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-1 ehow any injury or other traumatic event, the Medical Examinat must be notified at any injury or other traumatic event, the Medical Examinat must be notified at agrics.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	Kline Hospice Hou	se			Mt. Air					Frederi	ick	
	5. Social Security Number 6. S		7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs.	B. Date of Birti (Month, Day	h v. Year)	9. Bi	rthplace (S	tate or Foreign
=	009-03-8350	☐ M 2 🔯 F	87	Yrs.	Wichard Days	1100/3	1	May 5,	1916	Vei	mont	
	Usual Residence of Decedent											
	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						_	de City Limits
to Be Completed by Funeral Director	Maryland Frederic	k	Walk	ersvil	le						12	Yes 2 No
e	10e. Street and Number				10f. Zip Code				10g. Citi:	zen of What C	ountry?	
2	0016 7 1 7				01700					1 0.		
2	8816 Eureka Lane	12 Was Dog	edent Ever in U	6 12.1	21793	ianagia Ori	sie? /Coos	idu Von or No		ted Sta 14. Race - Am		
	11. Marital Status	Armed Fo	rces?	.5.	Was Decedent of H f Yes, specify Cuba	in, Mexicar	i, Puerto R	ican, etc.)		Black, Wh		211,
7	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □ Yes If Yes, Gir	/8		1 ☐ Yes 2 X ☐ No	Specify:				Specify:		
0		Year or D	ates:	<u> </u>							Vhite	
e la	15. Decedent's Ed (Specify only highest gra			(Give	lent's Usual Occup kind of work done	during mos	t of working	9		nd of Busines:		
흗	Elementary/Secondary (0-12)	College (I-4or 5+)		OO NOT use retired				Gove	rnment		ting
3	12			Accoun	nting Tec					Office		
9	17. Father's Name (First, Middle, Last,					18. Mothe	r's Name (First, Middle,	Maiden	Sumame)		
2	Jacob Nathan					Te1	a Ude	lafsky				
	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street	and Numbe	or Or Rural	Route Numbe	r, City or	Town, State,	Zip Code)	
	Sylvia Elfman - D	aughter		8816	Eureka L	ane,	Walke	rsvill	e, M	larylan	d 217	93
	20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of		Da	te	20c. Lo	cation - City o	r Town, Sta	te
	1 XBurial 2 Cremation 3		State Kin	emetery, cren g David	natory or other place I Memoria	(2)	/11/0	1001		•		
	*4 ☐ Donation 5 ☐ Other (Specif		-	Gard	lens	4	/11/2					irginia
	21. Signature of Funeral Service Licer	1500	anº	- 1	Name and Addre		. ota	uffer	Fune	ral Ho	me	
	Sharon Can	elle o	oller	e 10	521 Oposs	umtow	n Pik	e, Fre	deri	.ck, Ma	rylan	d 21702
-	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that o	aused the deat	h. Do not ente	er the mode of dyin	g, such as	cardiac or	respiratory are	rest,		Appro	dimate di Between
	Immediate Cause (Final	10/	otact	Litie	1,1110	Car	1600	,				and Death
	disease or condition resulting in death)	a. VV	or as a conseq	CO (C	Lung	Cer	n Ce				- Nu	DUM
	- 1	000 10	(or as a conseq	derice or).	1							
-	Sequentially list conditions,	b	or as a conseq	uence of):								
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 (0	(01 43 4 0011304	dones ory.								
20	that initiated events resulting in death) Last	C. Dua ta	or as a conseq									
ũ		Dua to	or as a conseq	uerice or).								
3		d										
Dy Physicianymedical Examiner	IF CELIAL S.										1	
	IF FEMALE: 23b. Was decedent pregnant		come of pregna		Catania arangan				2	3d. Date of de	livery	
2	in the past 12 months? 1 □ Yes 2 Ø No	4☐Pregn	irth 2 □ Feta ant at time of d		Ectopic pregnancy Other <i>(specify)</i>					Month	Day	Year
73	9 Unknown	9□ Unkn	own									
=	Part II. Other significant conditions of	ontributing to d	eath but not res	ulting in the ur	derlying cause give	en in Part I.		23e. Did to	bacco us	se contribute t	o the cause	of death?
	cance	Cal	chexi		, -			1 🗆 Y	es 2	INO 317 P	robably	4 Unknown
5	- Ca - W	<u> </u>	_U-U /-U							No.		
completed								24a. Was a autop:				ings available of cause of
5								perfor	med? 2 X No	death? 1 ☐ Yes		
9	25. Was case referred to medical					26. Place	of Death (Check only or				ru- interessoras e
0	examiner? 1 ☐ Yes 2 📉 No	Hospital:	npatient 2	ER/Outpatien	t 3□ DOA Oth	or.		9 5 ☐ Reside		Sother /Ca	ospic	e House
- 1	27. Manner of Death	28a. Date	of Injury	28b. Time of	28c. Injun			d. Describe h			cily)	- 77 77
5	1 Natural 5 ☐ Pending	(Mon	th, Day Year)	Injury	Worl	k? Yes 2 ⊡1						
2	2 Accident investigation 3 Suicide 6 Could not b		of being Ast			, 33 & []		f Loopting 10	teast ==	(M	10	A4 4
	4 Homicide determined	288. Place	of Injury - At he ng, etc. (Specif	om e, rarm, str e y)	et, factory, office		28	If. Location (S City or Town	n, State)	i Number or R	urai Houte	Number,
2												
Medical Certification.	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the	best of my kno	wledge, death	occurred at the tin	ne, date an	d place, an	d due to the c	ause(s)	and manner a	s stated.	ISO(s)
ed	one)	and man	ner stated.		osigation, in my o	Julion, deal		at the time, t	a to allu	piaco, allu du	o to the cat	130(3)
Ξ	29b. Signature and title of certifier				29c. License	number	111	2	9d. Date	signed (Mon	th, Day, Ye	ar)
	N A.7 H	G(A)	CIMI)	D	+41	04		4	18/0	4	
	30 Name and address of parson who	completed cour	a of death /lton	n 23a) /Tune	Print) / i		0	0 1		/	2	
	30. Name and address of person who	> Lun A	i L.K.	Z TUT	mas Bl	2500	· Dr	Fred	Will	MMO	217	62
	17-2.1100/16	11.00	40.	, , , , ,								

5

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

1				State of Maryland / De 27, Per ME, 0830, 4/27/04		•	•	
				27,1 er 145,0000,4/2//04	ertificate of Death	Reg	. No. 200 L	12210
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Medic		DONALD WILLIA	AM DeBRICK		April (03 2004	11:41 A ^M
7	Examin	er	4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Dea	ath	4c. County of Deat	h
			1202 Baltimore Av		Ocean City		Worcest	
	Funeral Director		5. Social Security Number 213-36-3910 Usual Residence of Decedent	M 2 F 7. Age (In yrs. last birthd	Months Days Hours Mir		(ear) 9. Birth Co	nplece (State or Foreign untry) PA
	land		10a. State 10b. County	10c. City, Town or	r Location			10d. Inside City Limits
	Mary	호	MD Worces	ter O	cean City			1 XYes 2 ☐ No
	1 the	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Co	untry?
	38 o	O K	1202 Baltimore A	ve. Apt. 4	21842		USA	
	deat me 2	Funeral	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Ame	
ထ္	after or the		1 Never Married 2 Married	1XXYes 2 □ No	1 ☐ Yes 2 X No Specify:	into Hican, etc.)	Black, White	
21215-0036	raff,	d by	3 □ Widowed 4 X X Vorced	Year or Dates: 1960-62	TEL Tes ZIA NO Specify.		Specify: W	hite
ν Ω	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or teme 23s or 28s-f show int, the Medical Esand of must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	(Completed)	cedent's Usual Occupation ive kind of work done during most of w	orking 16	b. Kind of Business/l	ndustry
7	ithin	Jdu	Elementary/Secondary (0-12)	College (1-4or 5+)	e. DO NOT use retired)			
2	led w lygie her ti nt. It.	S	12		Clerical		ederal Gov	/ernment
2	be find the property of the pr	Be	17. Father's Name (First, Middle, Last)		_	ame (First, Middle, Ma.	,	
2	d Mer nark	스	Unknown	7		etta Gazet		
Maryland	12 sh h and 7 ts n traun		19a. Informant's Name/Relationship (Type		ailing Address (Street and Number or F			,
ф ф	1 and Heatt In 2		Judith DeBrick 20a. Method of Disposition		01 Fox Chase Circ			
0	if ite		1 Burial 2 Cremation 3 R	emoval from State cemetery, o	crematory`or other place) 4/16	5/04	c. Location - City or 1	
‡	t. Partmer		'4 □Donation 5 □Other (Specify)		enlopen Crematory		rankford,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Hopportune If Item 27 is marked other than "natural", or itema 23a or 28a-1 show any piportune or other traumatic event, The Medical Examination or other traumatic events.		21. Signature of Fall Service License	way	22. Name and Address of Facility 108 William St.	Burbage I Berlin, MI	Funeral H	ome
40.			23a. Pert1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. Do not e cause on each line.	enter the mode of dying, such as cardia	ac or respiratory arrest		Approximate Interval Between
6-1	Pnysician	. 1	Immediate Cause (Final disease or condition	Atherosclerotic (ardiovascular Disease			Onset and Death
	/Medical	1	resulting in death)	Due to (or as a consequence of):				7 10
	Examiner		Sequentially list conditions, b					
		ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				
	acute and trans	Examiner	that initiated events c					
760,	ficate be executed physician and is the burial-transit		resulting in death) Last	Due to (or as a consequence of):				
976	ate b hysic the bi	Ilcal	d					
Вох 68	that the death certificat ed by the attending phy detached for use as th	Physiclan/Medic	IF FEMALE:					
<u>@</u>	ath ce	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death	3 Ectopic pregnancy		23d. Date of deliv	•
E	e dea he at	sicl	1 ☐ Yes 2 ☐ No	4□Pregnant at time of death 9□Unknown	5 Other (specify)		Month	Day Year
P.O.	at the	Phy	9 🗆 Unknown					
Ś	The law requires that the death certificate tie has been signed by the attending phys bage 2 should be detached for use as the	þ	Part II. Other significant conditions con	tributing to death but not resulting in the	e underlying cause given in Part I.		co use contribute to	
010	een s	ted				1 🗆 Yes	2 2 0 3 □ Pro	bably 4 Unknown
Division of Vital Records,	has by	Completed				24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
<u> </u>	The ate h	Sol				performed	? death?	2 □ No
ita Ita	Attending Physician: The death. actor: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?			ath (Check only one)	12.75	
\leq	Physic this c	၉	1 ☐ Yes 2 ☐ No	ospital: 1 Inpatient 2 ER/Outpat		Home 5 ☐ Residence	e 6 Other (Speci	fy) at scene
ב	ding P h. After funera	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injur	y Work?	28d. Describe how	njury occurred	
<u>s</u>	eath. or: A	catl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 Yes 2 No			
≥	or Att	Certification;	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rur tate)	al Route Number,
	urs a aral D			1				
	Nospital or Attenc 24 hours after death Funeral Diractor: etely filled in by the	edical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 1 ☐ Certifying Phys 2 ☑ Medicel Exemin	icien: To the best of my knowledge, de er: On the basis of examination and/or	eath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner as a and place, and due t	stated. o the cause(s)
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Med	29b. Signature and title of certifier A	and manner stated.	29c. License number		Date signed (Month,	
)	¥ × × 0			/ I/h	O.C.M.E.		ril~04 , 20	
7			1 X 10 MA	111		Ap	111 04, 20	JU 4
			30. Name and address of person who cor	npleted cause of death (Item 23a) (Typ	₁₁ Penn Street, Ba	ultimore. M	arvland 2	1201
	Sta	to	31. Date filed (Month, Day, Year)	20 Delhietzaria Signatura		11		
	Sta Registr		APR 1 6 20	104 Marion 15	Grante			

Description		State of Maryland	Certificate of Death	Reg. No. 2004 12211
Social Security Number Continuum Care Continu	Physician		Month	eath 3. Time of Death
Continuum Care Continuum Care Continuum Care Sykesville Carroll Sykesville Continuum Care Sykesville Conti	/Medica	Tridred Cacherine Darnari		
Top State Top County Top	Examine			
10a. State 10b. County 10c. Chry, Town or Location 10d. Indeed Dily Limits 10d. Street and Number 10d. Street 10d. Street and Number 10d. Street and Number 10d. Street 10d. Stre		213-01-6027 1 ¹ M 2 ¹ S8	t birthday) Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of B Months Days Hours Min. Jul. Jul.	9. Birthplace (State or Foreign Country) 18, 1915 Maryland
17. Father's Name (First, Middle, Maichen Surmame) 18. Mother's Name (First, Middle, Maichen Surmame) 17. Father's Name (First, Middle, Maichen Surmame) 18. Mother's Name (First, Middle, Maichen Surmame) 18. Informant's Name/Fleiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17. Father's Name (First, Middle, Maichen Surmame) 18. Informant's Name/Fleiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17. Father's Name (First, Middle, Maichen Surmame) 18. Informant's Name/Fleiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17. Father's Name (First, Middle, Maichen Surmame) 18. Informant's Name/Fleiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17. Father's Name (First, Middle, Maichen Surmame) 18. Informant's Name/Fleiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17. Father's Name (First, Middle, Maichen Surmame) 18. Informant's Name/Fleiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17. Father's Name (First, Middle, Maichen Surmame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17. Father's Name (First, Middle, Maichen Surmame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17. Father's Name (First, Middle, Last (Pather) Number, City or Town, State, Zip Code) 17. Father's Name (First, Middle, Maichen Surmame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17. Father's Name (First, Middle, Maichen Surmame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	ylend Now		Town or Location	10d. Inside City Limits
17. Father's Name (First, Middle, Maichen Surmame) 18. Mother's Name (First, Middle, Maichen Surmame) 17. Father's Name (First, Middle, Maichen Surmame) 18. Mother's Name (First, Middle, Maichen Surmame) 18. Informant's Name/Fleiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17. Father's Name (First, Middle, Maichen Surmame) 18. Informant's Name/Fleiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17. Father's Name (First, Middle, Maichen Surmame) 18. Informant's Name/Fleiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17. Father's Name (First, Middle, Maichen Surmame) 18. Informant's Name/Fleiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17. Father's Name (First, Middle, Maichen Surmame) 18. Informant's Name/Fleiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17. Father's Name (First, Middle, Maichen Surmame) 18. Informant's Name/Fleiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17. Father's Name (First, Middle, Maichen Surmame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17. Father's Name (First, Middle, Maichen Surmame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17. Father's Name (First, Middle, Last (Pather) Number, City or Town, State, Zip Code) 17. Father's Name (First, Middle, Maichen Surmame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17. Father's Name (First, Middle, Maichen Surmame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	e Mar	Maryland Frederick	New Windsor	1 ☐ Yes 2 ☐XNo
17. Father's Name (First, Middle, Makien Summane) 18. Mother's Name (First, Middle, Makien Summane) 17. Father's Name (First, Middle, Makien Summane) 18. Informant's Name (First, Middle, Makien Summane, Name (First, Mid	ath with th	10e. Street and Number 10701A McKinstry Mill Rd.	21776	U.S.A.
17. Father's Name (First, Middle, Makien Summane) 18. Mother's Name (First, Middle, Makien Summane) 17. Father's Name (First, Middle, Makien Summane) 18. Informant's Name (First, Middle, Makien Summane, Name (First, Mid	0036 ours aftar de rrai', or itema	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	Specific
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Pipe Creek Cemetery 3/26/2004 nr. Linwood, MD	212 3 withii jiene. r than	Elementary/Secondary (0-12) College (1-4or 5+)		own home
Physician //Medical Examiner Physician //Medical Examiner Og ag of a resulting in death) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Og ag of a resulting in death) Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Og ag of a resulting in death) Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Og ag of a resulting in death) Og ag of a resulting in death of a resulting in the underlying cause given in Part I. Og ag of a resulting in death but not resulting in the underlying cause given in Part I. Og ag of a resulting in death but not resulting in the underlying cause given in Part I. Og ag of a resulting in death but not resulting in the underlying cause given in Part I. Og ag of a resulting in death but not resulting in the underlying cause given in Part I. Og ag of a resulting in d	nd %	1/. Father's Name (First, Middle, Last)		
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Pipe Creek Cemetery 3/26/2004 nr. Linwood, MD	Mal	The state of the s		13/25/2005
Physician / Medical Examiner 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death	nore, and the standard or other	1XXXBurial 2 ☐ Cremation 3 ☐ Removal from State	e of Disposition (Name of Date letery, crematory or other place)	20c. Location - City or Town, State
Physician / Medical Examiner 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death	altin			
Physician Medical Examiner Medical Examiner Me	W FOFF	La Harine Vanter		
Physician Medical Examiner Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but		23a. Part 1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac or respiratory	arrest, Approximate Interval Between
Due to (or as a consequence of): Compute	/Medical	disease or condition	s Is	luck
Cause (Disease or influence of that initiated events resulting in death) Last Cause (Disease or influence of that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 21 No 3 Probably 4 Unknown available prior to completion of cause		Due to (or as	s a consequence of):	Guenthe
Cause (Disease or influence of that initiated events resulting in death) Last Cause (Disease or influence of that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 21 No 3 Probably 4 Unknown available prior to completion of cause	wacuted and al-transi	Sequentially list conditions, if any, leading to immediate	s a consequence of).	1 11
O'd 's part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2000 3 Probably 4 Unknow 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause	8760 sate ba e shysiclar the buri	Cause (Disease or injury that initiated events resulting in death) Last	s a consequence of):	/mm /h
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death 1	U = n = .		y trust infection	Manh
24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No 2 N	the dea	Part II. Other significant conditions contributing to death but not resulting		
24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Yes Yes	S, P	Vene to a		7.10 1700 12.11.11.1
TO SEE SEE SEE SEE SEE SEE SEE SEE SEE SE	s been s		24a. Wa:	ormed? available prior to completion of cause
25. Was case referred to medical 26. Place of Death (Check only one)	The la ate ha page		10	Yes 2 No 1 □ Yes 2000 No
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Oth	Vita	25. Was case referred to medical	Othor	
Comparison Com	g Phys er this seral di			
Section State Section	SiOr eath. or: Aft	O 142Natural 5 Pending investigation investigation	M 1 Yes 2 No	
Natural Suicide Accident Suicide	DIVISOR AND SERVING AND SERVIN	4 Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office 28f. Location City or To	(Street and Number or Rural Route Number, wn, State)
27. Manner of Death Natural Natural Accident Signature of Death Notice of Death Notic	Hospits 24 hours Funer letely fills	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowle and manner stated.	dge, death occurred at the time, date and place, and due to the and/or investigation, in my opinion, death occurred at the time	cause(s) and manner as stated. , date and place, and due to the cause(s)
			29c. Licensa number	29d. Date signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	MZ	30. Name and address of person who completed cause of death (them 25		20109
Wilbur Kis 295 Stone Ave St 307, Westmingter MD 21157		Willow Kis 295 Stone A	tre St 307, Westmingter	MD 21157
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 3 0 2004		31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 3 0 2004	e de l	
DHMH 16 Rev 6/95				

		1 - For State Registrar	State of Maryl	and / Dep		of Hea	ilth and	Mental Hyg	giene leg. No.200	
Dhynia	a.e.	Decedent's Name (First, Middle, Las	t)					2. Date of Dea Month		3. Time of Deat
Physici /Medi Examir	cal	Michael James Dil 4a. Facility Name (If not institution, give			4b. City, T	own, or Loc	ation of Deat	April	4 200 4c. County of E	4 0312
Funeral		Union Hospital of 5. Social Security Number 6. Se	7. Age (In	yrs. last birthday		Year If	Under 24 Hrs	8. Date of Birth	Cecil 1955 9.	Birthplace (State or Fore
Director		Usual Residence of Decedent	MM 2□F	48 Yrs.		ouys	OUTS NAME.	Septemb	er 20, Pe	nnsylvania
a Marylar Ba-f ahov	Director	Maryland Cecil		. City, Town or L :1kton	ocation					10d. Inside City Lin
th with th	al Dire	10e. Street and Number 474 Willow Drive			10f. Zip (og. Citizen of What	
within 72 hours after death with the Maryland ane. than 'netural', or itema 23e or 28e-f ahow he Madigal Exercine must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No lf Yes, Give Year or Dates:	in U.S. 13.	 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 ☒ No Specify: 			Specify Yes or No- nto Rican, etc.) 14. Race - An Black, Wi		Vinerican Indian, Vinite, etc. White
ithin 72 ho he. han "netur Medical	Completed by	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	done durin	g most of wo	rking	16b. Kind of Busine	ess/Industry
ba filad stal Hygi ed other	To Be Cor	12 17. Father's Name (First, Middle, Last) Angelo Dilenno		Labo	rer		Mother's Nar	me (First, Middle, I	Manufact Maiden Sumame)	uring
		19a. Informant's Name/Relationship (7 Robin Ann DiIenno				Street and	Number or Ru	ıral Route Number	City or Town, State	
permit. Pages 1 ar Department of Hea mportant: If item iny injury or othe		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (S)	Hemovariion State	b. Place of Dispo cemetery, cre 1kton Ce			Apr	i1 7.	20c. Location - City ${ m Elkton}$, M ${ m Mass}$	
permit. Pages 1 Dapartment of H Important: If its any injury or ott		21. Signature of Funeral leg ice Licer		2	2. Name and	Address of	Facility Co	rouch Fur	neral Hom	e ryland 2190
Physician /Medical Examiner physician and physician and physician and physician site physician s	Ical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Usease or injury that initiated events resulting in death) Last	a. Acute Hea Due to (or as a con CAD Due to (or as a con C. High Chol Due to (or as a con Cardiores	sequence of): sequence of): Lesterol sequence of):		st				Interval Between Onset and Death
Physician: The law requires that the death certificate this certificate has been signed by the attending phy rai diractor, page 2 should be datached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	⊒Ectopic prec ⊒ Other (spec			-	23d. Date of Month	delivery Day Year
equires that an signed b		Part II. Other significant conditions of Tobacco abuse	ontributing to death but not	resulting in the u	inderlying cau	ıse given in	Part I.			e to the cause of death? Probably 4 □Unknow
Physician: The law requires to this certificate has been signed as director, page 2 should be considered.	Completed by	Congestive heart						24a. Was ar autops perform	y prior ped? death	
certificat	BeC	High Blood Press 25. Was case referred to medical examiner?	ure			26.	Place of Dea	th (Check only one		′es 2□ No
Physicia this cert ai diract	္	1 ☐ Yes 2 ☒ No		28b. Time o		Other: 4	☐ Nursing H		nce 6 Other (S	pecify)
. p	Certification;	1 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year		м	Work?	2 🗆 No		w injury occurred	
To the Hospital or Attandil within 24 hours after death. To the Funeral Directors oc completely filled in by the fu		4 Homicide determined	building, etc. (Sp.	ecify)				City or Town	, State)	Rural Route Number,
na Hospital 24 hours a na Funaral i	Medical	2sa. Certifier 1 ☑ Certifying Phy (Check only 2 ☐ Medical Exam one)	sician: To the best of my iner: On the basis of exam and manner stated.	k rowedge, deat nination and/or in	n accumed at vestigation, in	the time, do n my opinion	ate arid place n, death occu	, and due to the ca rred at the time, da	ate and place, and o	due to the cause(s)
To the 1 within 2 To the 1 complet	Ž	29b. Signature and title of certifier	.000			icense nur			9d. Date signed (Mo	onth, Day, Year)
0		30. Name and address of person who o		Item 23a) (Type.	DC Print)	100 CC	756	on imi	418104	
3		Opden Coksy	por 1 223		ain St	eet	EKH	on imi),	
Sta Registi	_	31. Data Find (Month, Day, Year) (1)	32. Registrar's Si	gnature	,					

State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registra 12213 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Alberta L. Duvall Mar. 24, 2004 10:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** National Lutheran Home Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 217-12-1321 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, May 29 Birthplace (State or Foreign Country) **Funeral** Year) 917 1 □ M 270 F 86 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28e-f show the Medical Examiner must be notified at Md. Montgomery Rockville Director 1 Yes 2 □ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 9701-Veirs Drive 20850 238 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be fited within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: ð Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 Bookkeeper Not Available 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental I Carl K. Duvall Edna R. Reifsnide ೭ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traisonce. Rev.Dr.Reichard-Executor 9701-Veirs Dr., Rockville, Md. 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Mt.Olivet Cemetery-3/29/04 *4 □Donation 5 □ Other (Specify) Frederick. Md. 21. Signature of Funeral Service 22. Name and Address of Facility
Hysong Co., Inc.
6510-16th St. NW Wash DC 23a. Part1. Enter the disease, or conshock, or heart failure. List only used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical toffor as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause to the ca in Examiner (or as a consequence of) The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I ed by the a detached f 9☐ Unknown 9 ☐ Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has t irector, page 2 s autopsy performed? 1 ☐ Yes Hospitel or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Maturai 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 28f. Location (Street and Number or Rural Route Number, City or Town, State) thin 24 hours after of the Funeral Direct of the Funeral Direct ompletely filled in by 4 - Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel within 2 To the I 29b. Signature and fittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 24. 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr.Charles W. Karesh- 9701-Veirs Dr., Rockville, Md. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAR 3 0 2004 Registrar

		•	1 - For State Registrar	State of	Maryland		rtment <i>tificate</i>			nd Me		giene Reg. No.	7 11111	12214
	Physicia		Decedent's Name (First, Middle, Last Robert	")	De	cker					2. Date of Dea Month March	Day	2004 Year	3. Time of Death 5:57 PM
,	/Medic Examin		4a. Facility Name (If not institution, give	ve			4b. City, T	ingt				4c.	County of Dea	th ery
	Funeral Director		5. Social Security Number 6. Security Number 1069-32-9610 Usual Residence of Decedent	X XM 2□F	7. Age (In yrs. Ia	Yrs.	Months	Days	Hours	Min	8. Date of Birtl (Month, Day Aug. 3	/, Year)	C	thplace (State or Foreign ountry) EW York
BAITIMORE, IMARYIBING ZIZIO-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury og-other traumatic evant, the Medical Evantment he notified at any injury og-other traumatic evant, the Medical Evantment he notified at any since.		To Be Completed by Funeral Director	10a. State 10b. County Maryland Montgome 10e. Street and Number 9833 LaDuck Dr. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grave) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) George Decker 19a. Informant's Name/Relationship (1) Hank Binger - Co- 20a. Method of Disposition	12. Was Dece Armed Fo 1 □ Yes If Yes, Giv Year or D: ucation de completed) College (1 4 Type, Print) US IN	Ke: dent Ever in U.s rces? 2 No e ates: -4or 5+)	16a. Deced (Give life. I	On 10f. Zip 20 Nas Deced f Yes, spec 1 Yes 2 dent's Usua kind of work boo NoT us sulta ng Address ir Gr sition (Nam	ent of Hi fry Cubar X No I Occupa & done of retired, mt	specify: ation turing most 18. Mothe Mar and Numbe Road.	of working of Name Ty RO TO TO THE RESERVENCE OF TO THE RESERVENCE OF TO THE RESERVENCE OF THE RESERVE	(First, Middle, maska	U 16b. Kin Co Maiden Ir, City on na,	nd of Business	erican Indian, te, etc. White White Whodustry S Zip Code)
Baltimor	permit. Pages Department of Important: If ii any injury oca		1 Burial 2 Cremation 3 Care April 2 Cremation 3 Care April 21. Signature of Funeral Service Licen 23a. Part 1. Enter the disease, or companion, or heart failure. List only	see	State St.	. Char	les C Name an Donoh 290 P	emet d Addres ue-C ost	ery s of Facility ecere Ave.,	Fun Wes	eral Ho tbury,	me NY	elawn,	Approximate Interval Between
9,00,	ate be executed XX in the hysician and hysician and the burial-transit in the burial-transit in the burial transit in the hybrid in the burial transit in	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Diab Due to Hype	emic He (or as a consequence Me (or as a consequence c	uence of): litus uence of): n	sease						n	Onset and Death 1 Year 10 Years 20 Years
O. Box o	death certific e attending p id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live b	tcome of pregna pirth 2 Petal nant at time of de own	death 3	□Ectopic pr □ Other (sp					4	23d. Date of de Month	Dlivery Day Year
7	law requires that the as been signed by th 2 should be detache	Ď	Part II. Other significant conditions of	ontributing to d	eath but not resu	ulting in the u	nderlying c	ause give	en in Part I.	_				o the cause of death?
Leco	The ate h page	Completed											death?	utopsy findings available completion of cause of s 2 \(\square\) No
Division of Vital Records,	Attanding Physician: There is death. ector: After this certificate by the funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Yes 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 26b. Place of Death (Check only of Death (Check onl					ienc <i>e</i> (ecify)			
DIVIS	or At after of Direction by	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	build	of Injury - At ho ing, etc. (Specify	v) 				li.	City or Tov	vn, State)	îural Route Number,
)	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	29a. Certifler (Check only one) 29b. Signature and title of certifler	niner: On the to	e best of my kno asis of examina ner stated.	wledge, deat tion and/or	vestigation	, in my o	pinion, dea e number	d place, a	d at the time,	date and 29d. Dat	and manner a place, and du	e to the cause(s) th, Day, Year)
	•	ate	30. Name and address of person who Stephen Hellman, 31. Date filed (Month, Day, Year)	M.D.	6240 Mc	ntrose	e Rd.	, Ro		le, N	nd 2085	4		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 2004 10:45pm Peter Dempsher March /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1**X** M 2□ F Director 043-03-3855 84 Sept. 1919 Pennsylvania 3, Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f ehow traumatic event, the Madical Examiner houst be notified at 1 X Yes 2 □ No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 13204 Ridge Drive 20850 Funeral <u>United</u> States 12. Was Decedent Ever in U.S. Armed Forces? 1 13 Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bfack, White, etc. e filed within 72 hours after of Hygiene. I Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No þ Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Industrial Engineer Engineering permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 Is marked othe ery injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Michael Dempsher Mary Urda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eve B. Dempsher (Wife) 13204 Ridge Drive, Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Sky View Memorial Park 3/31/2004 Tama ua, Pennsylvania 21. Signature of Funeral Service Licenses 22. Name and Address of Facility deVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 feet X/h 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Examiner Sequentiafly list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the buria P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by sign 1 be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 Yes 2□ No 2 🕅 No 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending Injury after death.
I Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral (1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the the 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Dav. Year) 2 2004 March 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suhair Abulfarag, MD 481 N. Frederick Avenue, Gaithersburg, MD 20879 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 3 0 2004 Registrar

		State of Maryland / D	epartment of Health and No Certificate of Death	Mental Hygie	-	1221
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) MARVIN MAX DENENBURG 4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL	4b. City, Town, or Location of Death	2. Date of Death Month MARCH 26	Day Year 2004 4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 222−16−9479 1£2 M 2□ F 76	day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yo MARCH 6,	9. Birth Cou	place (State or Foreigr intry) DE
Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town MARYLAND MONTGOMERY SILVER S				10d. Inside City Limits 1 ☐ Yes 2 🎇 No
death with the Maryland ms 23a or 28a-f show	Funeral Director	109. Street and Number 10921 INWOOD AVENUE 11. Marital Status 12. Was Decedent Ever in U.S.	10f. Zip Code 20902	UN	. Citizen of What Cou ITED STATI	ES OF AMER
hours after d	by	1 M Never Married 2 Married 1 Yes, 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerlo 1 ☐ Yes 2₺ No Specify:		Black, White	etc. CTE
be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Evantrar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) O CLER	ecedent's Usual Occupation Sive kind of work done during most of work fe. DO NOT use retired) K	ing	b. Kind of Business/Ir RETAIL	dustry
nould be file d Mental Hy narked oth natic event,	0	17. Father's Name (First, Middle, Last) JACOB DENENBURG 19a. Informant's Name/Relationship (Type, Print) 19b. Name/Relationship (Type, Print)	REBA POL			
of Health and item 27 is nother traur		SHIRLEY D. KAPLAN/SISTER 591 20a. Method of Disposition 20b. Place of Disposition	Aailing Address (Street and Number or Rura 2 PLAINVIEW ROAD, Bisposition (Name of crematory or other place)	ETHESDA,		20817
permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other traumatic events.		Dubdilai 2 Cremation 3 Minemoval noist State	VID MEML GDNS 03/28 22 Name and Address of Facility DANZANSKY-GOLDBERG 1170 ROCKVILLE PIKE	MEMORIAL	ALLS CHURC	INC.
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. LUNG CANCER Due to (or as a consequence of)	enter the mode of dying, such as cardiac o		, mili	AND 20852 Approximate Interval Between Onset and Death 6 MONTHS
P C P	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of) c. Due to (or as a consequence of)				
sician: The law requires that the death certificate certificate has been signed by the attending phys rector, page 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliver	ery Day Year
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fter this	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No Ho spital: 1 Inpatient 2 ER/Outpate 27. Magner of Death 1 Natural 5 Pending investigation (Month, Day Year) 28a. Date of Injury (Month, Day Year)	e of 28c. Injury at 2		6 □Other (Specify	/)
ro tne Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)		City or Town, St	,	
within 24 hours after d within 24 hours after d completely filled in by	Medical	29a. Certifier (Check only one) 1 △ Certifying Physician: To the best of my knowledge, of the basis of examination and/of and manner stated. 29b. Signature and title of certifier	29c. License number	ed at the time, date a	and place, and due to Date signed (Month, a	the cause(s)
5		30. Name and address of person who completed cause of death (Item 23a) (Ty DR. G. PATRICK MURPHY 1500 Forest 0	D41624 pe. Print) Hen Road, Silver Sp	ring. Mar	$\frac{3}{26}$	010
Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	doors	3,		

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		Decedent's Name (First, Middle, Last)		-		2. Date of Dea	ath	3. Time of Death
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Exam		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Dea	th	4c. County o	f Death
		Montgomery Gener			01ney	Tull			omery
Funera Directo		3,0 30 30 10	х]м 2∭ F 7. Ag	e (In yrs. last birthda) 61 Yrs.	Months Days	If Under 24 Hrs Hours Min		v. Year)	9. Birthplace (State or Foreign Country) North Carolina
pue M		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
Aaryla f sho	č		rv	Si1	ver Sprin	σ			1√ Yes 2 □ No
the T	100	10e. Street and Number			10f. Zip Code	ъ		10g. Citizen of Wi	nat Country?
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death	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent of If Yes, specify Cub	Hispanic Origin? (S	Specify Yes or No-	14. Race	- American Indian, , White, etc.
or ite			1 ☐ Yes 2 【☐ If Yes, Give Year or Dates:	No	1 ☐ Yes 2X No		10 (110411, 010.)	Specify:	
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withii ene.	1	Elementary/Secondary (0-12)	College (1-4or:	5+)	ralegal	-,		Law	
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Jid be Alenta rked tic ev	Į.	Eugene Lyon				Annie	B. Hunt		
is 1 and 2 should be filed within 72 hours after death with the Maryland is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The 21s marked other then "naturel", or items 23a or 28e-f show other treumetic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationship (T			iling Address (Stree				
and		Vida Dickey-Niles	Daught		333 Long	Green Dr			
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permit. Pages. Department of the Importent: If its any injury or of	- BOUCE	21. Signature of Funeral Service Licens	1100a	MWV		lem Road	Oxford,		65
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/Medica		disease or condition resulting in death)	a. Sepsis Due to (or as	a consequence of):					J Days
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ysicie ysicie s cert direct	9	examiner? 1 ☐ Yes 2X No	Hospital: 1X Inpati	ent 2 ER/Outpati	ent 3 DOA	han	Home 5 ☐ Resid		(Specify)
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7		30. Name and address of person who co Godewill 0. Okoji	completed cause of	death (Item 23a) (Typ	e, Print)		ama Park		
Regi	State istra	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	Spark		Janua I UI N	,	

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	23a. Part 1. Ente	or the sease, or con	nplications that caused y one cause on each tir	the death.	Do not ente	er the mode of dyir	ng, such as	cardiac or	respiratory ar	rest,	ingt		Approximate
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 U 0 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Corinne Doyle 0115 MAKCH 26,2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** SAMOY SPRING BROOKE GROVE KEHABILITATION AND NURSING CENTER MONTGOMERY If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 026-26-6987 1 □ M 2 □XF 90 Director 12/09/1913 Boston, MA. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Sandy Spring 1X Yes 2 No Montgomery Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20860 18131 Slade School Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: White If Yes, Give Year or Dates: ፩ 3 1 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nursery School Owner-Operator other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If Item 27 is marked of Julia Bruno Anthony Baglione 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code/3 4 1 1 0 Richard H.Doyle/Son Collier County, FL 2032 Teagarden Lane 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Cemetery 3/30/04 Franklin, MA. 20a. Method of Disposition 20c. Location - City or Town, State ö 1 □ Burial 2 □ Cremation 3 □ Removal from State in jury 4 Donation 5 Other (Specify), 21. Signature of Juneral Service Licente PHILIP D. RINALDI FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 9241 Columbia Blvd.Silver Spring, Md20910 **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a. PULMONARY EMBOLUS

Due to (or as a consequence of): MINUTES Examiner Examiner DEEP VEIN THROUBDSIS/COMMON FEMORAL the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): esn for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? detached ALZHEIMER'S DISEASE 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown δ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 No this certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other:

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Natural 5 Pending investigation 2 ∏ No after death. 2 Accident 1 TYes Director: 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after
To the Funeral Directory Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D42046 - ATTENDING PHYSICIAN address of person who completed cause of death (Item 23a) (Type, Print) GRACE BROOKE HULFMAN, M.D. 18100 SLADE SCHOOL ROADSANDY SPRING MARYLAND 20860 31. Date filed (Month, Day, Year) MAR 29 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene 2 0 0 1

				State of Ma	aryianu	Cer	tificate	of L	Death		Reg. No.	JUU	12220
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podification of the Marylating A 12.13-0020 permit. Peges 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hyglena. Important: if Item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Madical Exeminar must be notified at once.	Completed by	15 (Specify of Elementery/Secondar 12	. Decedent's Edu only highest grad ury (0-12)	lication le co <i>mpleted)</i> College (1-4or 5	i+) 1	6e. Deced (Give k life. D	ent's Usual O kind of work d OO NOT use n Homen	_	ution uring most of wo	rking	16b. Kind of B	usiness/Indu	stry
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グ		30. Name end eddress Cynthia K 31. Date filed (Month, L	attner-5	ands, MD.	William	nspor	4 74 mi		Willian	nsport,	Maryla	nd 2	1795
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	/Medic			te Lee Del	ouney			April	2 300	
	Examin	er	4a. Facility Name (If not institution, give Washington County				Location of Death		4c. County of Dea	
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	arylar show	5	10a. State 10b. County Maryland Washingto	nn l	10c. City, Town or Lo					10d. Inside City Limits 12€Yes 2 □ No
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	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Health and Mentat Hygiene. ortant: if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Macitael Examiner must be rediffied at injury or other traumatic event, the Macitael Examiner must be rediffied at .		Charles Delouney -	husband	1537	Broadford	ding Road	, Hagers	town, Mar	yland 21740
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State		natory or other plac	e) Anri	Date 1 6,	20c. Location - City or	Town, State
Ĕ	Pages ment of h ant: if its		'4 □Donation 5 □ Other (Specify)			en Cemete	ry 20	004		, Maryland
Baltimore,	permit. Page Department o Important: if any injury or once.		21. Signature of Funeral Service Licens	0		2. Name and Addres			Funeral Ho	
	40 2 6 0	Н	23a. Part1. Enter the disease, or comp	lications that sauced						Maryland1740
-	Physician		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each lin	e.	Λ	Infa	/		Interval Between Onset and Death Tunnediate
	/Medical Examiner		resulting in ceatiny	Due to (or as a	consequent of):	././	. /	1:	.0	
		- e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):	vasa	ujai a	15845		
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
oʻ	be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or as a	consequence of):					
3760,	e ys	ical	(d						
68 ×	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE:							
Вох	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 Fetal death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
0	the a	ysic	1 ☐ Yes 2 X No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	time of death 5 L	Other (specify)				
4	that the the the the the the the the the th		Part II. Other significant conditions co	ntributing to death bu	t not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
Records,	quires n sign ald be	Completed by	Chronic Obst	ru Anie	lung	Disque	54	Ye	s 2 No 3 P	robably 4 Dunknown
000	s been si	ojete	Essential	Her per	tensión			24a. Was an	24b. Were a	utopsy findings available
Re	ysician: The lav is certificate has director, page 2	mo		7 /				autopsy perform	prior to death? No 1 Yes	completion of cause of
Vital	ian: rtifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Death			
of V	Physician: this certificatal director,	To E	1 Yes 2 No	Hospital: 1 ☐ Inpatier			4 Nursing no	me 5 Residei	nce 6 □Other (Spe	ocify)
n o	ffer free	on:	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Work		28d. Describe hor	w injury occurred	
Sio	Attending or death. ector: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be	Office Place of Join	a. At home form at		Yes 2□No	29f Location /Ctr	eet and Number or R.	usel Coute Number
Division	or fte	Certification:	4 Homicide determined	building, etc	ry - At home, farm, str . (Specily)	eet, factory, office		City or Town,	State)	urai Houte Number,
	Hospital 24 hours Funeral etely filled	<u>a</u>	29a. Certifier Certifying Phy	sician: To the best o	f my knowledge, deatl	h occurred at the tirr	ne, date and place,	and due to the ca	use(s) and manner a	s stated.
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	Medical	(Check only 2 Medical Exam one)	iner: On the basis of and manner star	examination and/or in	vestigation, in my or	pinion, death occurr	ed at the time, da	te and place, and due	e to the cause(s)
	To the Hospital within 24 hours a To the Funeral completely filled it	Me	29b. Signature and title of certifier	\bigcirc		29c License	e number	29	d. Date signed (Mont	ih, Day, Year)
•	1		May E Wals	911		663	815	1	April 3	2004
,	4-1		30. Name and address of person who c			Print)	1/	/	14.00	
2	1		MARY & Mones	7 MO) 3	-1 .0 [11]	STI	tagers!	Town	mil) 2	1780
	Sta Registi		31. Date filed (Months Jano 1975)	JU4 32. Janistra	r's Signature	will	,			
	3		*****							

	•	For State Registrar			artment of H rtificate of L			Reg. No.		
Physicia	an	1. Decedent's Name (First, Middle, Las					2. Date of E Month	Day		3. Time of Death
/Medic	al	Lewis Elmer Da 4a. Fecility Name (If not institution, give)	4b. City, Town, or	Location of D	MARCH eath		2004 County of Deeth	8: 00 P
Examin	ei							W	ASHINGT	ON
Funeral Director		RAVENWOOD LUTHER 5. Social Security Number 6. Se 532-12-3185	XM 2 F	ge (In yrs. last birthday, 91 Yrs.	Months Days	If Under 24 I Hours N	Ain. B. Date of B. (Month, L. Dec. 1,	irth Day, Year)	9. Birthi	place (State or Foreign ntry) nington
>		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
Shoy	ō	,	hington	Too. Oily, Town of E	Hagersto	าพท				1 X Yes 2 □ No
natural', or Items 23a or 28a-f show Jical Examiner must be notified at	Director	10e. Street and Number			10f. Zip Code	- ***		10g. Citiz	zen of What Cou	ntry?
23a o	aD	1183 Luther Dr.			2	21740			U.S.A	A
or ryperior and retural; or liems 23s or 28s-f show svent, to Medical Exertion must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Tyes 2 X Il Yes, Give	?	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? n, Mexican, Pi Specify:	(Specify Yes or Nuerto Rican, etc.)		14. Race - Americ Black, White, Specify:	
tural'	ed p	15. Decedent's Edi	Year or Dates:	16a, Dece	edent's Usual Occupa	ation		16b. Kir	nd of Business/In	
then "natic	Completed	(Specify only highest grad	College (1-4or	5+) (Give	e kind of work done of DO NOT use retired trical Eng	furing most of)	working		eral Gov	
other t	e Co	17. Father's Name (First, Middle, Last)		FIEC	rrical Eng		Name (First, Midd			erment
rked o	To Be	Lewis E. Danes				Porti	a M. Cro	ssland	đ	
iem 27 is marke other traumatic		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mail	ing Address (Street a	and Number of	Rural Route Num	ber, City or	Town, State, Zip	Code)
em 27 is m other traum		Fredric L. Danes	(Son)	3525	Rushing R	Rd. Aug				
If item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Tremation 3 ☐	Removal from State		osition (Name of matory or other place	I A -	Date 1 2004		cation - City or To	
ortant: injury		'4 □ Donation 5 □ Other (Specify			g Cremato	- 5	r.1,2004	Smi	ithsburg	,Md.
Important: If ite any injury or of once.	1	21. Signature of Funeral Service Light	pour	•	2. Name and Addres	,	12525 l e Smithsl	Bradbu Durg,N	ry Ave. 4d. 2178	3
		23a. Part1. Enter the disease, or comp shock, or heart lailure. List only of	lications that cause one cause on each	d the death. Do not en ine.	iter the mode of dying	g, such as care	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
ician		Immediate Cause (Final disease or condition resulting in death)	a. PM	Lemonica	a asp	ivale	or			2 weign
dical iner		Todaling in doubly	Due to (or as	a consequence of):	bleau	2 -	dine			24.
	<u>e</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):	Hunce	70	ume	-		nacy
s the burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	c.							
urial-t		resulting in death) Last	Due to (or as	a consequence of):						
the bi	dicai		d						-	
for use as		230. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy			2	3d. Date of delive	•
hed for	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			Other (specify)				Month	Day Year
detached		Part II. Other significant conditions of	entributing to death	but not resulting in the o	anderlying cause give	en in Part I.	23e. Did	tobacco us	se contribute to the	he cause of death?
۾ ۾	ed by						1	Yes 2]No 3□ Prob	pably 4 QUnknown
has been si	Completed						24a. Wa	s an opsy	24b. Were auto	psy lindings available impletion of cause of
e di	E O						per 1 ☐ Yes	formed?	death?	
ector. p	Be	25. Was case referred to medical examiner?				26. Place of	Death (Check only			
of d	2	1 ☐ Yes 2 2 No		ent 2 ER/Outpatie		4 Nursin	g Home 5 ☐ Re			y)
huner	o.	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury 28b. Time of Injury	Work	rat t? res 2 □ No	28d. Describe	how injury	occurred	
y the	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of In	jury - At home, farm, st		65 2 10	28f. Location	(Street and	i Number or Rura	al Route Number.
d in b	Certification:	4 Homicide determined		tc. (Specify)	oot, tablely, street			own, State)		
To the Funeral Director: Atter the completely filled in by the funeral	edical C	(Check only 2 Medical Exam	iner: On the basis	of my knowledge, dea of examination and/or in tated.	nvestigation, in my op	oinion, death o	ccurred at the time	, date and	and manner as s place, and due to	tated. the cause(s)
the mple	Me	29b. Signature and title of certifier	2 / 4	h .	29c. License	number		29d. Date	signed (Month,	Day, Year)
<u> </u>		Manyey	9 News	\neg	9	22426		2	7	
		7-0	(1"	. V	-	-070	2	G	- 21-00	1
5		30. Name and address of person who of Aw2 AR.	completed cau	death (Item 23a) (Type 368 mu rar's Signature	Print)	- Haar	rotorus.	141	- 31-06 0 2174	0

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DANES, Lewis Elmer

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Physician /Medical Examiner	JEANN 4a. Facility Name	(If not institution,	ULIA E		HAUI	PT Y	4b. City, 1		Location of		2. Date of E Month	Pa Pa	. County of	904 C	Fime of Death
Funeral Director	5. Social Security 213-36-	Number 6	6. Sex 1 ☐ M 2 □	7. Age (/	in yrs. last	birthday) Yrs.	If Under Months		If Under Hours		8. Date of B (Month, I 9/28/	irth Day, Year) 1937	9	Birthplace (Country)	State or Foreig
e or 28e-1 show the notified at	Usual Residence of 10a. State	of Decedent 10b. County Worce	ester	10		own or Lo									side City Limit: XYes 2 □ N
3e or 28e-1 si it be notified Il Director	10e. Street and No.	_{umber} . Atlanti	ic Ave.	#104			10f. Zip	Code 1842	2			_	tizen of Wha	at Country?	
Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other treumatic event, the Mudical Experiment matter profiled at once. To Be Completed by Funeral Director	11. Marital Status		12. Was Arme	Decedent Eve d Forces? 'es 2 XNo s, Give or Dates:	er in U.S.		Was Decedif Yes, spec		spanic Ori n, Mexicar Specify:		ecify Yes or N Rican, etc.)	lo-	Black,	American Inc White, etc. White	dian,
ygiene. t. ma Muscall. Completed	(Special Special Speci	15. Decedent's ecify only highest condary (0-12)	grade comple	ted) ge (1-4or 5+)	1	(Give life.	dent's Usua kind of wor DO NOT us retar	k done d e retired,	<i>luring</i> mos	t of worki	ng			ness/Industry	
Mental Hygis arked other stic event, in	17. Father's Name	e (First, Middle, La				Jec	ii etai	y			(First, Middle)	e, Maider	Sumame)		
tth and h		Name/Relationshi												ate, Zip Code y , MD	
nent of Hea int: If item ; iry or other	20a. Method of Di		3 Removal f	rom State		e of Dispo etery, crer	sition (Nam natory or ot Mem	e of her place	9) 3	3/127		20c. L	ocation - Ci	ty or Town, S e , MD	
Departm Importe any inju pnce.	K .\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Juneral Service Li	icensee	3 L Die 1-	<u>+</u>	22	2. Name and	Addres	s office	Bur Ber	rbage lin, M	Fune	ral H 1811	lome	
nysician Medical	23a, Part1, Enter	r Ind disease, eart failure. List of e (Final tion	nly one cause	on each line.		Do not ent		of dying			r respiratory			Inter Onse	oximate val Between et and Death
xaminer ច	Sequentially list of any, leading to cause. Enter Uncause (Ulphase of that initiated even	derlying or injury nts	b	e to (or as a c											
ysicia ne bur	resulting in death	Last	d.	e to (or as a c	neupeano	ice of);									
ed by the attending ph detached for use as th detached for use as the	IF FEMALE: 23b. Was decede in the past 1 1 Yes 2 9 Unknow	2 months? 2 □ No	1 L 4 D	i, outcome of ive birth 2 (Pregnant at tin Inknown	☐ Fetal de	ath 3	Ectopic pre						23d. Date o Month		Year
5 B B	Part II. Other sign	nificant condition	ns contributing	to death but r	not resultir	ng in the u	nderlying ca	use give	en in Part I			tobacco	/	ute to the cau	se of death?
2 5 6 E 2											24a. Wa	opsy formed?_	prio dea	ir to completion	ndings available on of cause of
cate has been s page 2 should											1 ☐ Yes	2 🖪 No	1	1163 201	
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2004 ROSIE MAE ELLIOTT MARCH 7:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner McCREADY MEMORIAL HOSPITAL CRISFIELD SOMERSET 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
OCT. 25,1917 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1□M 2XF Months Days Hours Yrs. Director 86 DELAWARE 220-18-7800 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other then "natural", or items 23e or 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Items 23e or 28e-f shov the Medical Examiner must be notified at MD SOMERSET MARION STATION Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5553 BURNETTSVILLE ROAD 21838 **USA** Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🛣 No WHITE Specify: þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -0-HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE **OMAR** MANSFIELD KATIE ELLEN HASTINGS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other tra WILLIAM RAYMOND SHANKS, JR/SON 5553 BURNETTSVILLE ROAD, MARION STATION, MD 21838 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CHESTERFIELD CEMETERY 3-25-2004 CENTREVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Spature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 that initiated events Due to (or as a consequence of) resulting in death) Last Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown \$ Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes ŽX No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After s efter dea... ral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours efter dea To the Funeral Director completely filled in by th 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D 48098 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) HALL HIGHWAY. CRISFIELD, MD · VIJAY KARUMBUNATHAN 31. Date filed (Month, Day, Year) 32. Registyr's Signature State Elsen & Sparter Registrar

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Etherton, Gloria

Amen	ided,#201	b, '	For State Registrar 20C,	F.H.,T	State o	f Mai 31/0	ryland / [)4,sbb	Depa <i>Cer</i>	rtment of H	lealth Death	and M	lental Hy	giene Reg. No.	2001	+ 12	225
		ne.	Decedent's Name (First									2. Date of De	ath		3. Time of D	Death
	Physici /Medic		Gloria El	izabe	th Eth	ert.	on					March	28 ,	2004	1550	М
	Examin		4a. Facility Name (If not in	nstitution, giv	e street and nu	mber)			4b. City, Town, or		of Death	A	4c. (County of Death		
4					ial Ho				East					Talbot		
- 1	Funeral		5. Social Security Numbe 218-28-03		ex □M 2√2F	7. Age 7.4	(In yrs. last bir	thday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bi (Month, Di	rth ay, Year)	9. Birth	place (State or ntry)	Foreign
,	Director		Usual Residence of Dece	J Z	21	, 1					l	1-6-1	930	Balt	imore	, MD.
	nyland how			County	-		10c. City, Tow							1	I 0d. Inside City	
	e Ma	cto	MD. T	albot			St. M.	ich	aels						1 X Yes	2 🗌 No
	or 28	Director	10e. Street and Number 104A. Wes	L ah-		a .			10f. Zip Code				10g. Citiz	en of What Cour	ntry?	
	s 23g	erai	11. Marital Status		12. Was Deci		vor in 11 S	12 W	21663	icnanio Or	ugin2 (Sn	poity Voc or N		JSA 4. Race - Americ	can Indian	
я Е. 336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, tra Madical Examination collied at once.	by Funeral	1 □ Never Married 2 3 ➡ Widowed 4 □ □		Armed For 1 Tyes If Yes, Gir Year or D	orces? 2 No ve X			Vas Decedent of Hi Yes, specify Cuba	Specify		Rican, etc.)		Black, White,	etc.	
Gloria 1 21215-0036	2 hou	ted	15. [ecedent's Ed	ducation de completed)		16a.		ent's Usual Occupa		at of work	ina	16b. Kin	d of Business/in	dustry	
2 2	ithin 7 19.	Completed	Elementary/Secondary		College (1-4or 5+)	life. D	kind of work done o OO NOT use retired	dring mos	SI OF WORK	ing				
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Etherton, lore, Maryland	should and Me mark matic	ဥ	Charles I			nus	196	. Mailin	g Address (Street a	-		_		Murray		
R P	nd 2 s lith ar 27 is r trau		Deborah E		,,	augl										
ie th	s 1 au of Hea itam othe		20a. Method of Disposition	ก			20b. Place of	Dispos	sition (Name of latory or other plac			Date	20c. Loc	ation - City or To		
Ethaltimore,	Page nent c unt: If ury or		1 □ Burial 2 🛱 Cre `4 □ Donation 5 🗆			State	Chri.	st (Churc h	4	3 - 31	-04	Bove St.	er, De. Michae	ls.MD .	
Balti	permit. Departn Importa any injt		21. Signature of Funeral	ull	24.	. 1		R.	rematory. Carro	ll H	urle	y Fun	eral	Home,	PC.	
			23a. Part1. Enter the dis shock, or heart failu	ease, or com	plications that o	caused the	ne death. Do	not ente	O BOX	518 g. such as	cardiac	or respiratory a	aels	, MD. 21	6A6p3ximate	000
	Physician		Immediate Cause (Final disease or condition		_	Ma	•	11	Lung	Ca	100	.0014			Onset and De	
	/Medical		resulting in death)		d		consequence	- / /	-026)	0	0.000				
J	Examiner	_	Sequentially list condition	19,	6			0								
	led Isit	nine	if any, leading to immedi- cause. Enter Underlying Cause (Disease or injury	ate data	Due to	(or as a	consequence	01):								
	sate be executed obysician and the burial-transit	Examiner	that initiated events resulting in death) Last		c. Due to	(or as a	consequence	of):								
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9	tificat ng phy as th	ledi														
O. Box	death cer e attendir d for use	Completed by Physician/Me	IF FEMALE: 23b. Was decedent preg in the past 12 montl 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			oirth 2 nant at ti	pregnancy Fetal death me of death		Ectopic pregnancy Other (specify)				23	3d. Date of delive Month	ery Day Ye	ar
م م	that ned by deta	y Ph	Part II. Other significant	conditions o	ontributing to d	eath but	not resulting in	n the un	derlying cause give	en in Part	l.	23e. Did t	obacco us	e contribute to th	ne cause of dea	ath?
rds	quires	q pa		char		1-10	bro 50	2				1 🗆	Yes 2□	100 3 DE 00	ably 4 □Un	known
Division of Vital Records, P.O	The law requir ite has been si bage 2 should	ompiet	Chon	ic 06	Stuc	ct	ive ,	PU1.	vicual	70	1,500	24a. Was auto perfo 1 □ Yes	an psy prmed? 2 No	24b. Were auto prior to con death? 1 \(\sum \) Yes	psy findings av	allable ise of
'ita	sien: artifica ctor,	Bec	25. Was case referred to examiner?	medical								Check only	one)		7	
5	shysic this co	၉	1 ☐ Yes 2 No			Inpatient								Other (Specify	y)	
n C	Jing F	ion		Pending	28a. Date (Mon	of Injury th, Day	Year) 28b. 1	Time of njury	28c. Injury Work	rat ⊲? Yes 2. □		28d. Describe	how injury	occurred		
isic	Attendi death. ctor; A y the fu	licat	2 ☐ Accident 3 ☐ Suicide 6 ☐	investigation Could not b		of Injun	v - At home fa	ırm stre	et, factory, office	163 2		28f. Location /	Street and	Number or Rura	I Poute Numbe	91
Div	- 9	Certification:	4 Homicide	determined	buildi	ing, etc.	(Specify)					City or To	wn, State)			
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier 1 (Check only one)	ertifying Ph dedical Exar	ysician: To the niner: On the b and man	asis of e	xamination an	e, death d/or inve	occurred at the time estigation, in my op	e, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) a date and p	and manner as st place, and due to	ated. the cause(s)	
	To the within To the comp	M	29b. Signature and title of	f certifier	1	1	0 1		29c. License	number			29d. Date	signed (Month,	Day, Year)	
			blen	nus !	k At	Le.	lal	7	000	53	110		3/	29/200	Y	
			30. Name and address of							<i>-</i> ·						
	Sta	te	Dennis De 31. Date filed (Month Da	y Yearla	32.	egistrar	s Signature	was	nrngton	St.	, Ea	ston,	MD.2	1601		
	Registr	ar	PA.	7312	004		B.	Sol	de							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day}2004 APRIL 3, **Physician** 10:35 AM DAVID ALAN ESPIE .TR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL 1542 ELLSWORTH AVE. CROFTON 8. Date of Birth (Month, Day, Year) DECEMBER 18, 1927 KY If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 X M 2 □ F 77 407-20-0606 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show and be notified at 1K Yes 2 □ No CROFTON ANNE ARUNDEL Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Itams 23a or USA 21114 1542 ELLSWORTH AVE. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes. Give Year or Dates: 145-146 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Exeminent permil. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Itan any injury or other traumatic event, Ita Mudical Exemi 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🏋 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ANNE ARUNDEL COUNTY 4 LAW ENFORCEMENT 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be RUBY MARTIN DAVID ALAN ESPIE SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CROFTON, MD 21114 1542 ELLSWORTH AVE. VIRGINIA F. ESPIE/ WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 4/9/2004 LOUISVILLE, KY CALVERY CEMETERY 22. Name and Address of Facility ROBERT E. EVANS FUNERAL HOME 21. Signature of Funeral Service License 11 16000 ANNAPOLIS ROAD BOWIE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GACER 18 mont **Physician** /Medical Due to (or as a consequence of) **Examiner** Squentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical the use as IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II, Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ peq 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy pertormed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? After Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No M death. 2 Accident the hours after deat 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 ☐ Homicide hin 24 hours a the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5Me 300 B U Bistug Levin 31. Date filed (Month, Day, Year) State

Registrar

APR 0

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Baltimore, Maryland 21215-0036

			i icuse i		Department of Health and	-	_
			1 - For State Registrar	otate of Maryland	Certificate of Death	Reg. f	2001 1222
			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physici /Medic		rear! L	UCEALLE	Ewell		28 2004 10:00 AM
7	Examin	er	4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Dea	th	4c. County of Death
Н	Funeral		5. Social Security Number 6. Sex	NG FACILITY 7. Age (In yrs. last b)	Pocomoke Ci	8. Date of Birth	Norcester Co,
В	Funeral Director		225-32-9959 10	M 2XF 80	Yrs. Months Days Hours Min		9. Birthplace (State or Foreign Country) VIRGINIA
	and w		Usual Residence of Decedent 10a, State 10b, County	10c. City, Tov	vn or Location		10d. Inside City Limits
	Maryla f sho	ō	VA ACCOMI	14	2		1 Yes 2 No
	r 28e	irec	10e. Street and Number	1011	10f. Zhe Code	10g. (Citizen of What Country?
	hours after death with the Maryland turel', or liems 23e or 28e-f show al Examinational be myllied at	Funeral Director	544 Willow Sti	-eet	2333	6 4	SR
	items items	une	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
036	urs aft	þ	3 Widowed 4 □ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 KNo Specify:		Specify: BLACK
21215-0036	72	Completed	15. Decedent's Educ (Specify only highest grade	ation 16a	Decedent's Usual Occupation (Give kind of work done during most of work)	16b.	Kind of Business/Industry
121	within then then	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of wo	1/	1
	Hyg Hyg ent,		17_ Father's Name (First, Middle, Last)	Tr		me (First, Middle, Maid	100seneeping
lan	Mental Mental rked c	To Be	Golden	Townse		ie Ho	Iliand.
Maryland	and N is mai		19a. Informant's Name/Relationship (Typ		b. Mailing Address (Street and Number or R		
-	s 1 and 3 f Health item 27 other tr		Goldie Mae Bonnevil		18 Lypphaven Dr. Vi	cloria Apt	. Poromoke, Md 21851
Jore	9°= 5		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Re	emoval from State	of Disposition (Name of ery, crematory or other place)	422 11	Location - City or Town, State
Baltimore	글 투원을 .		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service kisense	DEASC	hapel UMC Cometory Hou	113,4004 H	CRNTOWN, VA
Ba	permit. Departr Import any Inj		W Sen So	the		Fourth Street	t Pocomoke, Md
			23a. Part1. Enter the disease or complice shock, acheant failure. List only on	ations that caused the death. Do	not enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	activisele	colie Cardiovasc	elas Des	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):		
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):		
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760,	te be executed ysician and ne burial-transit		resulting in death) Last	Due to (or as a consequence	of):		
687	# × 6	dicai	d.				
Box (eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy	_		23d. Date of delivery
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☑No	1 Live birth 2 ☐ Fetel death 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Year
P.0	that the de ted by the a	Physician/Med	9 Unknown				
ds,	Se Ded	ρ	Part II. Other significant conditions cont	2 2 2	eta Melletus	23e. Did tobacco	o use contribute to the cause of death? 2 Mo 3 □ Probably 4 □ Unknown
of Vital Records,	w requir been si should	Completed	mulo: 1	0 2	nent.	24a. Was an	
Re	The lav	duic	C T'O	1/ 10 th	nenera	autopsy performed?	
ita		Be C	25. Was case referred to medical	yperlense	26. Place of De	1 ☐ Yes 2 💢 N ath (Check only one)	No 1 ☐ Yes 2 ☐ No
) \ \	dir is	ToE	examiner? 1 ☐ Yes 2 🕱 No	ospital: 1 Inpatient 2 ER/O	0.4	lome 5 Residence	6 ☐Other (Specify)
o uc	fter	lon:	27. Manner of Death 1 ANatural 5 □ Pending		Time of 28c. Injury at Work?	28d. Describe how inj	ury occurred
Division	Attending r death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa	M 1 ☐ Yes 2 ☐ No	28f Location (Street a	and Number or Rural Route Number,
<u>S</u>	el or / s after il Dire	Certification:	4 Homicide determined	building, etc. (Specify)		City or Town, Sta	te)
	To the Hospitel or Attendi within 24 hours after death To the Funerel Director: A completely filled in by the fu		29a. Certifier (Check only (C	cian: To the best of my knowledger: On the basis of examination ar	e, death occurred at the time, date and place nd/or investigation, in my opinion, death occurred	a, and due to the cause(s) and manner as stated.
	thin 24	Medical	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month, Day, Year)
	Z Z Z S		1	13,00	D 29505		3 - 29 - 2004
			30. Name and address of person who cor	npleted cause of death (Item 23a)			21-2004
			GREGORIO M. BEL	LOSO, M.D.; 530	2 CHINABERRY DR .; S	ALISBURY,	MD 21801
	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 1 20	32. Régistrar's Signature	1		
	_		11. O T (TOTAL PROPERTY AND A SECOND	Charles II		

			For	State of Marylan	d / Depa	artment	of Health a	nd Mental Hy	giene	
			1 - State Registrar		Cei	rtificate	of Death	1 a D. v/ D		004 12228
	Physici	an	Decedent's Name (First, Middle, Last					2. Date of D Month	Day	Yeer 3. Time of Death
	/Medic Examin		Demetria Gruspe 4a. Fecility Name (If not institution, give			4b. City. To	own, or Location of	March	21, 4c. County	2004 2:00 P.M
	LAGIIII	C1	5707 Longfellow				rdale		Princ	e George's
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.		If Under 1 Months	Year If Under 2 Days Hours	Min. (Month, D	rth av. Yeer)	Birthplece (State or Foreign Country)
	Director		Usuel Residence of Decedent	80	Yrs.			Dec. 2	2, 1923	Philippines
	iand ow		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Many a-f sh	tor	Maryland Prince G	eorge's Ri	iverda]	Le				1∭ Yes 2 No
	death with the Maryland rms 23a or 28a-f show rmust be medified at	Director	10e. Street and Number			10f. Zip C	Code		10g. Citizen of	What Country?
	ath w	ral	5707 Longfellow				20737		U.S.A	
	items items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 🏋 No	S. 13.	Was Decede	nt of Hispanic Orig y Cuban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	0- 14. Rad Bla	ce - American Indian, ck, White, etc.
920	urs af	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2	No Specify:		Specif	y: Asian
21215-0036	be filed within 72 hours after death with the Marylar Ital Hygiene. Id other than "natural", or items 23s or 28s-1 show of other than "natural", or items 23s or 28s-1 show event, Its Medical Examinat must be publical at	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Deced	dent's Usual	Occupation done during most retired)	of working	16b. Kind of B	usiness/Industry
2	Man .	mple	Elementary/Secondary (0-12)	College (1-4or 5+)			retired)			
2	Hygie thert int, In	C	12 17. Father's Name (First, Middle, Last)		House	Wife	18. Mother	's Name (First, Middle	Own H	
au	id be ental ked o	To Be	Dionisio Gruspe					na Almonte		,
Maryland	es 1 and 2 should be of Health and Menta I Item 27 is marked rother treumatic ev		19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mailir	g Address (or Rural Route Numb		State, Zip Code)
Ξ	and 2 salth a n 27 is		Elizabeth Estrada		2887	Arbel:	la Lane,	Thousand (Oaks, Ca	lifornia 91362
Baltimore,	of He of He If item or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F		lace of Dispo emetery, cren	sition (Name natory or oth	of er place)	Date	20c. Location -	City or Town, State
Ē	Pages tment of tant: If it		* 4 Donation 5 Other (Specify)	Arli						on, Virginia
Ba	permit. Pages 1 Department of H Important: If Ite any injury or ott		21. Signature of Funda Service Lice	Mylan				Gasch's Fu		
š.	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ay -			of dying, such as c	ardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Atrial Fibri Due to for as a consequ		on	- 2		- 146000	
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	ed sit	lnei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Decase or njury that initiated events	Due to (or as a consequ	uence of):					
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760,	te be executed ysician and e burial-transit	calE		d.						
89							1555		I I	
Box	death certificate be attending physic	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic preg	nancy		23d. Da	te ol delivery nth Day Year
o.	0 0 2	by Physician/Med	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5□	Other (spec	city)		IMO	iiii Day 16ar
1	The law requires that the de ite has been signed by the a page 2 should be detached (Ph	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the ur	nderlying cau	se given in Part I.	23e. Did	obacco use cont	nbute to the cause of death?
Records,	n sign							1 🗆	Yes 2∑No	3 Probably 4 Unknown
000	aw require s been sig 2 should t	Completed						24a. Was	an 24b. \	Were autopsy findings available prior to completion of cause of
	The law ate has page 2:	E O						auto perfo	ormed?	orior to completion of cause of death? I □ Yes 2 □ No
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					of Death (Check only		
	Physician: r this certifica ral director, p	2	1 ☐ Yes 2X No 27. Manner of Death		ER/Outpatien			sing Home 5 N Resi		1-F97
0	ing Afte	tlon	1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	M 280	linjury at Work? 1 ☐ Yes 2 ☐ No		how injury occurr	90
Division of	deal ctor / the	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, larm, str	eet, factory, o		28f. Location (Street and Numb	er or Rural Route Number,
á	P Sir fe	Certification;	4 Homicide	building, etc. (Specify	")			City or To	wn, State)	
	Hos Hur Hur Hur	Medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	rsician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at restigation, in	the time, date and my opinion, death	place, and due to the occurred at the time,	cause(s) and ma date and place,	nner as stated. and due to the cause(s)
	To the within 2 To the complete	X	29b. Signature and title of certifier			29c. l	icense number		29d. Date signed	d (Month, Day, Year)
1	2		100 m	- (my)			7146	6	March 2	24, 2004
/	5)		30. Name and address of person who co						1	
	Sta	te	Jeffrey Mazique 31. Date filed (Month, Day, Year)	, MD Walter 2. Registrar's Signat		Army N	redical C	enter, Was	hington	, D.C.
	Registr		MAR 3 0 2004	George &	Loon	E)				

			1 - State of Maryland / Department / Department / Department / Department / Department / Departm	artment of Health and Martificate of Death	ental Hygiei Reg.	000:
*	Physici /Medic		1. Decedent's Name (First, Middle, Last) LEE Maffett	ENNIS	2. Date of Death Month MARCH	28 2004 4:23 AM
	Examin		4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL	No. of the second	ITY	4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex $1 \square M$ $2 \square F$ 7. Age (In yrs. last birthday) $7 \cap M$ $2 \cap F$ 7. Age (In yrs. last birthday) $7 \cap M$ $2 \cap F$ $7 \cap M$ $2 \cap F$ $7 \cap M$ $2 \cap F$ $7 \cap M$ $2 \cap M$ $3 \cap M$ $4 \cap M$	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Jan. 8, 19	9. Birthplace (State or Foreign Country) Wash., D.C.
21215-0036	72 hours after death with the Maryland *natural, or Items 23a or 28a-f ehow dical Examinan must be notified at	eted by Funeral Director	Armed Forces? 1 Never Married 2 X Married 1 Yes, Give Year or Dates: WW II 15. Decedent's Education (Specify only highest grade completed)	10f. Zip Code 20715 Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto F 1 □ Yes 2 □ No Specify: dent's Usual Occupation kind of work done during most of workin	cify Yes or No- Rican, etc.)	10d. Inside City Limits 11\times 190 Yes 2 \(\text{No} \) Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White Kind of Business/Industry
	filed within Hygiene. ther then int, Ita Me	Be Completed	Elementary/Secondary (0-12) College (1-4or 5+) A C C O 17. Father's Name (First, Middle, Last)	unting Manager 18. Mother's Name	(First, Middle, Maid	ash. Gas Co.
, Maryland	nd 2 should Ith and Mer 27 le marke r traumatic	^C		Edith ng Address (Street and Number or Rural O Brunswick Ln.		
Baltimore,	Page nent o int: If iry or		1 Department 2 Cremation 3 Hemoval from State '4 Donation 5 Other (Specify) MD. Vet	erans Cem. 4-2- 2. Name and Address of Facility Be	2004 CI	neltenham, MD.
Ba	Dermit. Departn Imports any inje	7		512 NW Crain Hw	y. Bow	ie, MD. 20715 Approximate Interval Between
8760,	Physician / Medical Examiner bhivsicien and the prival-travsit the prival-travsit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. ASPIRATION Due to (or as a consequence of):	PNEUMONIA CARCINUMA OF	THE OR	Onset and Death 2 DAYS 2 DAYS 20PHARYNX YEAR
.O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as:	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
9	w requires that been signed by should be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		o use contribute to the cause of death?
al Records,		Completed			24a. Was an autopsy performed	
Vital	Physician: this certificand in the control of the c	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ★ npatient 2 ☐ ER/Outpatien	26. Place of Death		6 ☐ Other (Specify)
ion of	Jing After fune	atlon; T	27. Manner of Death 1 Natural 5 Pending investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year)		8d. Describe how in	
Division	ital or Attendris after death ral Director: led in by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	41	City or Town, St	
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only onl) 2 ☐ Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier	n occurred at the time, date and place, as vestigation, in my opinion, death occurre 29c. License number	d at the time, date a	and place, and due to the cause(s)
	2 1 1 1 5 E		Brut Mee	RES-000	MA	Date signed (Month, Day, Year) PCH 28 2004
21	5) Va Sta	ite	30. Name and address of person who complet of cause of de) th (Item 23a) (Type, BRETT MASAYES VA 600 NOR 31. Date filed (Month, Day, Year) 22. Registrar's Signature		BALTIMO	RE MARYLAND 21287
	Registi		MAR 3 0 2004 Keeper & Spen	W		

				For State Registrar		State o	of Marylar		artment of <i>rtificate of</i>		d Mental Hy	giene Reg. No.	2004	12230
		M a. 1.		1. Decedent's Name	(First, Middl	e, Last)					2. Date of Do	aath Day	Year	3. Time of Death
	**	Physicia /Medic				Margaret		Easle			March	23,	2004	12:55 P M
		Examin	er	4a. Facility Name (If			imber)			or Location of De	eath		County of Death	
			- 43	5. Social Security N		Hospital	7. Age (In yrs.	last birthday	If Under 1 Yea		Hrs. 8. Date of Bi		ontgomer 9. Birth	place (State or Foreign ntry)
		Funeral Director		498-20-43		1 ☐ M 2 🂢 F	78	Yrs.	Months Days	Hours V	In. (Month, D. April	ay, Year) 25 , 19	925 Miss	ouri
	2-2-10/2	*		Usuel Residence of			10.0							10d. Inside City Limits
		arylar show	_	10a. State	10b. County		10c. Ci	ty, Town or L						1 ☐ Yes 2 🛣 No
		eath with the Marylan is 23a or 28a-f show	ecto	Maryland 10e. Street and Nun		gomery		Poton	10f. Zip Code			10g Citi:	zen of What Cou	
		with With Liber	Ē	8560 Hor		Lane			,	0854			ted Stat	
		death ma 23	Funeral Director	11. Marital Status		12. Was Dec	edent Ever in U	J.S. 13.			(Specify Yes or Nuerto Rican, etc.)		14. Race - Amen	can Indian,
	9	or Ite	F	1 Never Marri	ed 2 <mark>∭</mark> Mar	ried 1 Tes If Yes, G	2 📉 No		1 ☐ Yes 2 ☑ No		ieno nican, etc.)	ŀ	Specify: Wh:	
	933	ural',	d by	3 Widowed		Year or I	Dates:							
	5-	itled within 72 hours after death with the Maryland Hygiene kher than "natural", or Itema 23a or 28a-f show wit, the Medical Ezamilinci must be notified at	Completed	(Spec		nt's Education st grade completed;)	(Give	edent's Usual Occi e kind of work don DO NOT use retir	e during most of	working	16b. Kir	nd of Business/Ir	ndustry
	12	d within jene. r than	ф	Elementary/Seco 12	ndary (0-12)	College ((1-40r 5+)		nemaker	,		70	wn Home	
	d 2	e fifed Il Hygie other	0	17. Father's Name	(First, Middle,	Last)				18. Mother's I	Name (First, Middle	, Maiden	Sumame)	
	/lan	Aenta Aenta rked tic ev	To B	Ernest	Starke	2				Margar	et Mary S	chae	ffernegg	gar
	Maryland 21215-0036	es 1 and 2 should be filed of Health and Mental Hygie of Health 27 is marked othar ir other traumatic event, If		19a. Informant's Na							Rural Route Numb	-		
		and ealth m 27 har tr				ley/Daugh					Potomac,		yLand 20 cation - City or T	
5	Baltimore,	Pages 1			Cremation	3 Removal from	i State		osition (Name of matory or other p		rch			
STA	Ħ	rtmen rtant njury		* 4 ☐ Donation 21. Signature of Fu			Mon		Crematorium				iesda, M	
125	Ba	permit. Pages 1 Department of H Important: If ite any injury or ot		In signature of Fu	hellest	arout	M0130)5 30	obert A. P O West Mon	umphrey Funtgomery A	meral Home Venue, Roc	/Rock kville	ville, In , Marylar	c. d 20850–2805
	*			23a. Part1. Epter to shock, or hea	he disease, o rt failure. Lis	r complications that t only one cause on	caused the dea each line.	th. Do not er	0.		diac or respiratory a	arrest,		Approximate Interval Between Onset and Death
		Physician		Immediate Cause	(Final on	a RE	SPIRA	tory	ta ILUI	E				Orisot and South
		/Medical Examiner		resulting in death)		Due to	(or as a conse	quence of):	(MRCT	PUCTL/4	S PULMOI	Van 4	DICCALL	Pro.
	1 a		e.	Sequentially list co	nditions, nmediate	b. St. Due to	(or as a conse		10 01331	10001102	> 1 wanto1	77101	1110136	
		uted d ansit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	erlying injury	`								
	o,	exec an and rial-tra	Exa	resulting in death)	Last	Due to	(or as a conse	quence of):						
2	3760,	ate be executed hysician and the burial-transit	ical			d								
3	39	certifica nding ph use as t	Med	IF FEMALE:		00. 1/								
4	Вох 68	Attanding Phyaician: The law requires that the death certificate be executed refeath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was deceden in the past 12	months?	1 ☐ Live	utcome of pregn birth 2 ☐ Fet	al death 3	□Ectopic pregnan □ Other (specify)	су		2	23d. Date of deliv Month	Pery Day Year
M	0	t the de by the a lached f	ysic	1 ☐ Yes 2 9 ☐ Unknown	No	9□ Unki	nant at time of nown	death 5	□ Other (specily)					
	0	that the		Part II. Other signi	ficant condit	ions contributing to	death but not re	sulting in the	underlying cause (given in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
	rds,	quires tha n signed ald be dei	D D	COR P41	-MONA	LE, DI	IERTIC				_ 1 🗆	Yes 2	□No 3□Pro	bably 4 Monknown
C	S	aw requir as been s 2 should	Completed by	CHRONIC	BRON	UCHITIS ,	EMPH	ty sem	A		24a. Was		24b. Were aut	opsy findings available ompletion of cause of
Margar	Re	The lav	E O									ormed?	death?	2 □ No
6	ital	stuffica ctor, p	BeC	25. Was case reference examiner?	rred to medica	al				26. Place of	Death (Check only			
9	> >	hyaic this ce al dire	2	1 □ Yes 2				ER/Outpatie	ent 3 DOA		ng Home 5 ☐ Res			fy)
5	n c	ing P	lon:	27. Manner of Deat	5 Pendi	iig	of Injury oth, Day Year)	28b. Time Injury	W	uryat 'ork? □Yes 2□No	28d. Describe	how injury	y occurred	
5	Sic	death death tor: /	icat	2 Accident 3 Suicide	6 ☐ Could		e of Injury - At I	home farm s	treet, factory, offic		28f. Location	(Street and	d Number or Rur	al Route Number,
of	Division of Vital Record	after Direction by	Certification:	4 🗌 Homicide	deten	mined 200. Flac	ding, etc. (Spec	ify)	arost, ractory, onto	•		wn, State,		
Easley		To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier (Check only		ing Physician: To the								
A		the H hin 24 the F nplete	Medi	one)	Λ-		nner stated.			nse number			e signed (Month,	
				29b. Signature and	21 /1	rds			N.	2657	1	2	2210	4
•		10		30 Namo and add	to s of percor	n who completed car	use of death /Ite	am 23a) (Tvos	Print)	7		-1	2710	
	-			TONTA	10- M	17USIN	(D) ((215	FERNW	10010	#401	DETTE	SOAIM	0 208/7
		St Regist	ate trar	31. Date filed (Mor	AR 29	2004	Registrar's Sign	nature	Sport	2				

			For State Registrar	State of Maryland		artment of F			iene 99. No. 200	4 12231
	Physici /Medic		Decedent's Name (First, Middle, Last JULIAN)		EICHLEI	R	2. Date of Death Month MARCH 1	Day Year	3. Time of Death 7:00 A M
	Examin	ALMORPH CO.	4a. Facility Name (If not institution, give WINTER GROWTH	street and number)		4b. City, Town, o	r Location of Death		4c. County of De	
	Funeral Director		5. Social Security Number 6. Se 080-28-3477 Usual Residence of Decedent	x 7. Age (In yrs. la M 2□F 93	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/06/19	Year) 9. B	irthplace (State or Foreign Country) YORK
	n the Maryland r 28a-f show	Irector	10a. State 10b. County MARYLAND MONTGOMER 10b. Street and Number		, Town or Lo			10	0g. Citizen of What C	10d. Inside City Limits 1 1 Yes 2 □ No Country?
9800	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-1 show calcal Ex., in etrical be multifulated	d by Funeral Director	15100 INTERLACHEN 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	DRIVE, APT. 72 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	S. 13. \	20906 Vas Decedent of H f Yes, specify Cuba 1 ☐ Yes 2X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:		U.S.A. 14. Race - Am Black, Wh Specify: W	ite, etc.
21215-0036	d within giene. ir then	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	DO NOT use retired	during most of work	ing	16b. Kind of Busines PHARMACY	s/Industry
Maryland	be file ital Hyg id oths avant,	To Be C	17. Father's Name (First, Middle, Last) $IGNATZ$	EICHLER			SALLIE	e (First, Middle, N	PINC	
Baltimore, Mar	Pages 1 and ment of Health ant: If itam 27 ury or other to		19a. Informant's Name/Relationship (T) HARRIET S. EICHLER 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 XI 4 □ Donation 5 □ Other (Specify,	NUFE 20b. Pice Normal Removal from State MT .	15100 ace of Dispo emetery, crem HEBRO	INTERLAC sition (Name of natory or other place ON CEMETE	CHEN DR., (ce) (RY 03/19)	APT. 72		
Bal	permit. Depart Import any inj		21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or compshock, or heart failure. List only of	Rudewig	ED 10	91 ROCKVI	EL FUNERA [LLE PIKE	, ROCKVI	LLE, MD 20	Approximate
8760,	Priyoician / Medical Examiner	al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. SENILE DEMENT Due to (or as a consequence of the following of the foll	TIA UN lence of): NSPECI lence of): TED	COMPLICAT				Interval Between Onset and Death 14 YEARS
.O. Box 687	at the death certificate by the attending physi tached for use as the I	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	d. 23c. If yes, outcome of pregnar 1	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of do	alivery Day Year
٥	es the	by	Part II. Other significant conditions co	ntributing to death but not resu	ilting in the ui	nderlying cause giv	en in Part I.			to the cause of death? Probably 4 □Unknown
Vital Records,		Completed						24a. Was ar autopsy perform 1 \(\text{Yes} \) 2	prior to death?	autopsy findings available completion of cause of s
of	Attanding Physicien: r death. ector: After this certific by the funeral director,	tlon: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending investigation	Hospital: 1 ☐ Inpatient 2 ☐ B 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4∑ Nursing Ho y at	h (Check only one ome 5 Resider 28d. Describe hor	nce 6 Other (Sp.	ecify)
Division	el or Attan s after deat il Director: ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or F , State)	Rural Route Number,
	To the Hospitel or At within 24 hours after or To the Funaral Direct completely filled in by	edical	(Check only 2 Medical Exam one)	rsician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	vestigation, in my o	pinion, death occur	and due to the ca red at the time, da	use(s) and manner a te and place, and du	is stated. e to the cause(s)
)	To the within 2 To the complete	W	29b. Signature and title of certifier Bewett MU			29c. Licens D476			IARCH 18,	
			30. Name and address of person who compared to the BENNETT MORRISON,	M.D., 2901 OLI	NEY-SA		NG ROAD,	OLNEY, M	ARYLAND 20	0832
	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 9 2004	32 Registrar's Signat	ture g	Sports	/			

		1 - For State Registrar	State of Maryland / Depa Cer	irtment of Health and I tificate of Death	Mental Hygier Reg. F	2004	12232
Physicia	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
/Medic Examin	al	VICTOR 4a. Fecility Name (If not institution, give st	ELIAS reet and number)	4b. City, Town, or Location of Death		4c. County of Death	
Funeral Director		061-28-6243	M 2□F 7. Age (In yrs. last birthday) 66 Yrs.	BETHESDA If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	ONTGOMERY 9. Birth Co. 937 YUGO	place (State or Foreign intry) SLAVI.A
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MARYLAND MONTGOMER	10c. City, Town or Lor	cation			10d. Inside City Limits 1 X Yes 2 □ No
with the	Director	10e. Street and Number		10f. Zip Code		Citizen of What Cou	intry?
De liled within 72 nouts after death with free maryland tial Hygiene. Ad other than "natural", or Items 23s or 28s-f show event, the Modical Examinar must be notified at	by Funeral	6809 CARLYNN COURT 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🕅 No	20817 Vas Decedent of Hispanic Origin? (Si Yes, specify Cuban, Mexican, Puerfill Yes 2∑ No Specify:	U.S. pecify Yes or No- to Rican, etc.)	14. Race - Amer Black, White	
one. Than "natural the Medical Ex	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation 16a. Deced (Give (Give life. L	lent's Usual Occupation kind of work done during most of wo DO NOT use retired) ENGINEER	rking	Kind of Business/lu	ndustry
z snould be filed withing and Mental Hygiene. Is marked other than aumatic event, I'm Ma	To Be Co	17. Father's Name (First, Middle, Last) MAURICE	ELIAS		me (First, Middle, Maid		ED
s I and z stroud f Health and Men Item 27 Is marke other traumatic	-	19a. Informant's Name/Relationship (Typ	e, Print) 19b. Mailin	g Address (Street and Number or Ru		y or Town, State, Zi	100
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury-or other tra once.		GERI B. ELIAS/WIFE 20a. Method of Disposition 1 ↑ Burial 2 ↑ Cremation 3 ↑ Received the Control of Co	20b. Place of Disportant State	CARLYNN COURT, B sition (Name of natory or other place) REMEMBRANCE 04/0	Date 20c.	Location - City or T	
Departme Importan any injur		21. Signature of Funeral Service License	DA	Name and Address of Facility ANZANSKY-GOLDBERG 70 ROCKVILLE PIK	MEMORIAL (CHAPELS,	INC.
Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the sath. Do not entre cause on each line URINARY THE AND GRAM NEGATIVE Due to (or as a consequence of):	RACT INFECTION WI	c or respiratory arrest, TH GRAM PO:	SITIVE	Approximate Interval Between Onset and Death 24 HOURS
physicien and physicien and sthe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	SARCOMA Due to (or as a consequence of): SEPTIC SHOCK Due to (or as a consequence of):				
The faw requires that the death certificate of executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of deliv Month	rery Day Year
quires man n signed by uld be deta	þ	Part II. Other significant conditions conf	tributing to death but not resulting in the ur	nderlying cause given in Part I.		o use contribute to 2 ⊠No 3 □ Pro	the cause of death?
ystcian: The law requir is certificate has been si director, page 2 should i	Completed				24a. Was an autopsy performed 1 Yes 2 1	prior to co	opsy findings available ompletion of cause of 2 No
To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifies completely filled in by the funeral director;	n: To Be	27. Manner of Death	ospital: 1 \(\times \) Inpatient 2 \(\times \) ER/Outpatien 28a. Date of Injury (Month, Day Year) Injury	t 3 DOA Other: 4 Nursing H	ath (Check only one) Home 5 Residence 28d. Describe how in		fy)
I or Attendir after death. Diractor: Al I in by the fu	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street City or Town, Sta		al Route Number,
Hospita 24 hours Funeral etely filled	edical C		ician: To the best of my knowledge, death ler: On the basis of examination and/or inv and manner stated.				
To the comple	Me	29b. Signature and title of certifier	Khomaj	29c. License number D58965		Date signed (Month,	
Sta	310	30. Name and address of person who con SAIMA KHAWAJA, M. D 31. Date filed (Month, Day, Year)	mpleted cause of death (Item 23a Type, 11114 ROCKVILLE 32. Registrar's Signature	Print) PIKE, SUITE 100,	ROCKVILLE	, MARYLAN	D 20852

			1 - For State Registrar	State of Ma	rylan		artment				ntal Hy	giene Reg. No	71111	122	33
			1. Decedent's Name (First, Middle, Las							2	. Date of D	aath Da	y Year	3. Time of D	
	Physicia /Medic		BERNYCE COH	EN Ep.	STE	12				1	MARCH		7,200	1010	AM
is .	Examin	er	4a. Facility Name (If not institution, give		-	CENTER			Location o			1 .	. County of Dear		
			BLOOKE GROVE REHABILIT				SANO			1100			lowido		-
	Funeral	1	5. Social Security Number 6. S 266-07-2926	ex 7.Age □M 2∑1F		last birthday) 91 Yrs.	If Under Months	Days	If Under	Min.	. Date of Bi	rth <i>ay</i> , Year,		hplace (State or	
₩.	Director	-	Usual Residence of Decedent			91 113.				0	7/20/	1912	PEN	NSYLVANI	.A
	ow a		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City	Limits
	Man P-f sh	to	MARYLAND MONTGOME	ERY	SANI	OY SPR	ING							1 ☐ Yes	2 X No
	or 284	Directo	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of What Co	ountry?	
	23a 23a	ral	18131 SLADE SCHOOL	ROAD				0860					ED STAT		IERIC
36	d within 72 hours after death with the Maryland Jiene. r than "natural", or Iteme 23a or 28e-f show The Mocical Examine must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 (∑Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🔯 N If Yes, Give Year or Dates:		}	Was Deced If Yes, spec 1 ☐ Yes 2		ispanic Ori n, Mexican Specify:	gin? (Speci n, Puerto Ri	fy Yes or N can, etc.)	0-	14. Race - Ame Black, Whit Specify: WI		
21215-0036	2 hou		15. Decedent's Ed			16a. Dece	dent's Usua	I Occupa	ation	t of working		16b. k	(ind of Business	Industry	
215	within 7 ene. then "n	ple	(Specify only highest gra	College (1-4or 5-	+)	life.	DO NOT us	e retired)						
2	filed will Hygien other the	Completed		4		RETAI	L BUS	INES					OTHING		
n	d ta b	Be	17. Father's Name (First, Middle, Last)							er's Name (i	First, Middle	e, Maider			
Ya	should be and Menta marked umatic ev	10	SAMUEL H. COHEN	Time Deleth		105 14-16	Add		DOROT		Paula Alumi	as City	GOLDBI or Town, State,		
Maryland	~ ~ ~ ~		19a. Informant's Name/Relationship (турө, Етип)								-			
45	of Health item 27	- 03	LEE EPSTEIN/SON 20a. Method of Disposition		20b. P	lace of Dispo	sition (Nan	ne of		Dat			MD 20904 ocation - City or		
nor	ages into into into into into into into into	1.1	1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif			emetery, crei DEAN M	-			3/30/	2004	OI.N	EY, MAR	YT.AND	
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or git		21. Signature of Funeral Service Licer	-	7 0 01								N, INC.	LELLING	
B	Per		> amanda	Kudewa		1	DWARD 091 R	SAG OCKV	EL FU ILLE	PIKE,	ROCK	$\Lambda \Gamma \Gamma \Gamma$	N, INC. E, MARY	LAND 208	352
Sec.	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused one cause on each lin a. NON - I Due to (or as a	Θ.	h. Do not en	ter the mod	e of dyin	g, such as	cardiac or i				Approximate Interval Betw Onset and D	reen
*	/Medical Examiner		resulting in death) Sequentially list conditions,	b										į.	
	ocuted nd transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a											
8760,	icate be executed physician and s the burial-transit	cal	leading in death, East	Due to (or as a	a conseq	uence or):									
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Feta	I death 3	⊒Ectopic pr ⊒ Other (sp						23d. Date of de Month		ear
	res that igned b be deta	by PI	Part II. Other significant conditions		at not res	ulting in the u	inderlying c	ause give	en in Part I				use contribute to		
ord	w require been si should I	ted	SENILE DEMS	AITH							1	Yes 2	No 3□P	obably 4 □Ur	nknown
Il Records,	vician: The law r certificate has bu rector, page 2 sh	Completed										s an opsy ormed? 2 No	prior to death?	utopsy findings a completion of ca 2 No	vailable use of
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth	-	e of Death (
of	this at di	10	1 Yes 2 No	1 🗆 Inpatie		ER/Outpatie	-)A	4/200			_	6 □Other (Spe	cify)	
		ation	1 Natural 5 Pending 2 Accident investigatio		Year)	Injury	M	8c. Injun Worl	k? Yes 2□		d. Describe	now inju	ny occurred		
Division	or A or A or A or Direction by	Certification:	3 Suicide 6 Could not b				reet, factory	, office		28	f. Location City or To		nd Number or R e)	ural Route Numb	· e r,
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical		nysician: To the best of miner: On the basis of and manner sta	examina										
	To the within To the comple	Me	29b. Signature and title of certifier						e number				ate signed (Moni	-	
	1		1 mm A	TTENDING P	HYS	ICIAN	I	742	046	0		MAR	CH 27,	2004	
	O		30. Name and address of person who GRACE BLOCKE HUFFA	completed cause of d	eath (Iten	п 23а) (Туре,	, Print)	. 0			00:	,	4.4.2	10	810
			GRACE BLOOKE HUFFA 31. Date filed (Month, Day, Year)	バイン、 1 (32. Registra	r's Signs	SLADE!	SCHOO	L Ko!	HD DA	mod =	2411	Cock	MARYLA	ND W	المال
192	St Regist	ate rar	MAR 2.9 20		المسالسطويم	19	100	anks.	1.						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** JAMES HUNTER EWING WARCH 2015 24,2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner SPRING BLOOKE GROUS REHABILITATION AND NULSING CENTER SANDY MONTHOMERY 8. Date of Birth (Month, Day, Y June 21, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) New Jersey **Funeral** Days Months Hours 1⊠M 2□ F Director 087-14-6431 Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Experient mat be rediffed in 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3425 St. Leonard's Court 20906 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Specify: White Saltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Yes Give Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Buchanan Ewing Belinda Meeks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3425 St. Leonard's Court, Silver Spring, MD 20906 Annette M. Ewing/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or of once. March 25 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2004 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ISPIRATION PNEUMONIA Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Sequentially list conditions, fary leading to in reduce cause. Enter Underlying Cause (Disease or injury Division of Vital Records, P.O. Box 68760, DISEASE that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 Probably 4 Unknown Completed by page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tyes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 TYes 2 □ No. death after death 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \(\text{Homicide} \) 24 hours Medical 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hou To the Funel completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) - ATTENDING PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GRACE BROOKE HURMAN, M.D. 18100 SLADE SCHOOL FOAD SANDY SRING 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

29 2004

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar 12235 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deathp **Physician** 31, 2004 EXLER March 7:50 M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Casey House 6001 Muncaster Mill Rd. Rockville Montgomery 8. Date of Birth (Month, Day, Year)
Dec. 18,1930 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₩ M 2□F Months Days Hours 73 Maryland Director 218-26-8228 Usual Residence of Decedent filed within 72 hours after death with tha Maryland Hygiene. 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits ral', or Itams 23a or 28a-f ahow Evanding rugst be putified at 1 ☐ Yes 2 ☐ No Maryland Montgomery Silver Spring Direc 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11700 Old Columbia Pike #1515 20904 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1XIYes 2 □ No If Yes, Give Year or Dates: Korean 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: þ 3 ₩ Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Bookkeeper Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If liem 27 is marked oth any injury or othar traumatic evant once. Jacob Exler Gertrude Voldman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bruce Exler, son 5500 Manistique Drive, Churchton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State Lebanon Cemetery | April 4,2004 Adelphi, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Fema al Sovice License Torchinsky Hebrew Funeral Home, Inc. 254 Carroll Street, NW, Washington, DC 20012

23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage Congestive Heart Failure 6 Months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? p 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should l Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate ha 1 Yes 2 🗖 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: $_{4\,\square\,\text{Nursing Home}}$ 5 \square Residence 6 \square Other (Specify) \square Hospice 2 1 ☐ Yes 2 😾 No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Harrison 6001 Muncaster Mill Road, Rockville, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 2 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 12236 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 2004 5, EVANS April 7:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett County Memorial Hospital Oakland Garrett 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F June 8, 73 Director 216-66-0660 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show The Medical Examinar must be notified at Director 1 ☐ Yes 2 ☑ No MD Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 122 Woodmont Lane 21550 IISA Funeral "naturel", or Items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status filed within 72 hours after Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. δ Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any lighty or other traumatic event sine. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Stanley Paugh Bessie Madaline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol M. Bittinger/daughter 122 Woodmont Lane, Oakland, Md. 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 4/8/2004 Mt. Zion Cemetery Swanton, Maryland 21. Signature of Funeral Service Licente 22. Name and Address of Facility Stewart Funeral Home M XX Crow 32 S. Second St., Oakland, Md. 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Congestive Heart Failure 1 Hour /Medical Due to (or as a consequence of): Examiner Arteriosclerotic Heart Disease Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chaits for as a consequence of) Examiner physician and s the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical as attending | IF FEMALE 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ⊠Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 Yes 2 No To Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 🖾 No 3₽ DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title certified 29c. License number 29d. Date signed (Month, Day, Year) D23979 4/6/04 i M.D. 311 N. Fourth St., Oakland, Md. 21550 30. None and address of erson who completed cause of death (Item 23a) (Typ), Robert A. Goralski 31. Date filed (Month, Day, State Registrar

			1 - For State Registrar	State of Maryland	d / Department of I			iene 2004	12237
ı	Physici		Decedent's Name (First, Middle, Virginia	Laudine	EDWARDS		2. Date of Death	Day Year	3. Time of Death
	/Medic Examin Funeral		4a. Facility Name (If not institution,		4b. City, Town, of the state of		8. Date of Birth (Month, Day,	4c. County of Deat	h
	Director		23342-9221 Usual Residence of Decedent	1□M 2⊠F 82	Yrs. Months Days	Hours Min.	Aug. 24,	1001	yland
	the Marylar 28a-f show	Director	MD G 10a. State 10b. County MD G	arrett 10c. City,	Town or Location Oak 10f. Zip Code	and	10	ng. Citizen of Whal Co	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
020	be filed within 72 hours after death with the Maryland ital Hygiene. bd other than "natural", or tlems 23a or 28a-f show event, the Medical Etal-factional be indiffed at	by Funeral	4337 Broadford 11. Marital Status 1 □ Never Married 2⊠ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces?	3. 13. Was Decedent of h	an, Mexican, Puerto	Decify Yes or No-	USA 14. Race - Ame Black, White	ncan Indian,
0-6121	within 72 ho ene. than "natur in Medical	ompleted	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire Metal W	during most of work d)	king	6b. Kind of Business/	,
ומוומע	ed la be	To Be Co	17. Father's Name (First, Middle, La Joseph A.	BEALS	Hetal W		e (First, Middle, M	teel Manuf Maiden Sumame) TIPPETT	
z, Ivial y	ith all			ds, Jr./husband	19b. Mailing Address (Street 4337 Broadf	ord Road	0akland	, Md. 2155	0
	Page nent o ant: If ury or		20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Service Li	Removal from State	ace of Disposition (Name of metery, crematory or other plant). O.F. Cemeters 22. Name and Addre	(e) 4/7	/04	Elk Garde:	v. WV
ם ח	permit. Departr Imports any inj		> Bradler	mplications that caused the death.	132 S. Seco	nd St., C	akland.	neral Home Md. 21550 _{st,}	Approximate
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.O. DOX 0	v requires that the death certifics been signed by the attending ph should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 DNo 9 □ Unknown	23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3 Ectopic pregnancy	/		23d. Date of deli Month	very Day Year
ı də, r	w requires that been signed b should be deta	by	Part II. Other eignificant condition	s contributing to death but not result	ting in the underlying cause giv	en in Part I.		acco use contribute to	the cause of death?
מו שבכים	n: The law re licate has bei r, page 2 shc	Completed	Carlou	ic arrythmu	las		24a. Was an autopsy perform 1 Yes 2	prior to c death? No 1 ☐ Yes	opsy findings available ompletion of cause of
10 10 10	To the Hospital or Attending Phyaiclan: The lav within 24 hours after death. To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2.	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Jeath 1 Natural 5 Pending investiga	28a. 1 te f Injury (Month, Day Year)	R/Outpatient 3 DOA Oth 28b. Time of Injury M 1	er: 4 🗆 Nursing Ho	h (Check only one me 5 ☐ Residen 28d. Describe how	nce 6 Other (Spec	ify)
	tal or Atters after dez	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office		28f. Location (Stre City or Town,	eet and Number or Rui State)	ral Route Number,
	the Hospi hin 24 hou the Funer npletely fill	Medical	(Check only 7 Medical Ex	Physician: To the best of my know aminer: On the basis of examination and manner stated.	on and/or investigation, in my o	pinion, death occurr	ed at the time, dat	e and place, and due	to the cause(s)
	Z W Z S		29b. Signature and fitte of certifier Child	no approprieted cause of death (Nem 2	29c. Licens	1263	33	d. Date signed (Month	04 04
	Sta	te	31. Date filed (Month, Day, Year)	32. Regishar's Signatu	Cumb	cilare) me	2 2150	2
	Registr		APR -	6 2004	M. Souls				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month NORALEE MARCH 31, 10:00 PM FERGUSON 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HERITAGE HARBOUR NURSING HOME ANNAPOLIS ANNE ARUNDEL 8. Date of Birth (Month, Day, Year)
JULY 23,1925 WASHINGTON, DC If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 XF 78 212-20-1889 Yrs Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location ral', or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No PRINCE GEORGES BOWIE Direct 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 4711 RAMSGATE LANE 20715 USA Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: WHITE 3 X Widowed 4 ☐ Divorced "natural" other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RECEPTIONIST MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mentai 27 is marked of traumatic ever ALBERT WEBSTER ROBINSON NORA IRENE HARMON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES RICHARD FERGUSON, SR/ SON 4711 RAMSGATE LANE Health a BOWIE, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. MD VETERANS CEMETERY 4/2/2004 CHELTENHAM, MD 22. Name and Address of Facility ROBERT E. EVANS FUNERAL HOME 16000 ANNAPOLIS ROAD BOWIE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) (arcine a /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any, reading to miniocials cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a nonsequence of) Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has b perfor 2 No 1 ☐ Yes 2 No 1 ☐ Yes or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one 1 Inpatient 2 ER/Outpatient 3 DOA Other. 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filled (Month, Day, Year 32. Registrar's Signature State Registrar

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		•	1 - For State Registrar	Otate of Marytai		rtificate of		a wichtai riy	Reg. No. 20	04	12239		
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		3. Time of Death		
	Physicia		Todd Alle	n Fuller				March	Day 20	Year 2004	11:40 p ^M		
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of D		4c. County		TT+40 I		
			5311 Buckeystow	n Pike		Frede				deric	k		
	Funeral		5. Social Security Number 6. Security Number 12. 12. 12. 12. 12. 12. 12. 12. 12. 12.	7. Age (In yrs. 25	last birthday) Yrs.	If Under 1 Year Months Days		lin. (Month, Da	Y. Year)	9. Birthpla	ose (State or Foreign And		
Η.	Director		Usual Residence of Decedent	2)				Juli. 1	, 19/0	nai y	rand		
	yiand now		10a. State 10b. County		ty, Town or Lo	cation				10	d. Inside City Limits		
	a-f s	ctor	Maryland Frede	rick		New	, Market				1 ☐ Yes 2 💆 No		
3	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Countr	y?		
	death with the Maryland ms 23a or 28a-f show finds be indiffed at	rai	7103 Stretch C				21774	V		I.S.A.			
	Item Der de	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No				(Specify Yes or No- uerto Rican, etc.)	Hace Black	- America k, White, et			
3	nours aner tural', or its	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□ Yes 2☑ No	Specity:		Specify:	Whit	:e		
Maryland 21215-0036	i z nous atter destri win tre maryan "natural", or items 23a or 28a-f show pilical Examiner must be inclifted at	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Occu	pation	working	16b. Kind of Bu	siness/Indu	ustry		
7	Mag	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	1	kind of work done DO NOT use retire technici		working					
7	be filed within 72 hd tal Hygiene. d other than "natul event, Its Medical		12 17. Father's Name (First, Middle, Last)			reciiiici		Name /First Middle		security systems			
and		Be	Jack A. Fuller	•				arolyn Wh		3)			
2	snould ind Men ind Men ind marke	ပ	19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Mailir	ng Address (Stree	1	Rural Route Numbe		State. Zip C	Code)		
	27 Is		Jack A. Fuller/ fa	ther		Stretch		New Mark					
<u>.</u>	other		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of natory or other pla	ice)	Date	20c. Location - 0				
Ĕ	ment of lant: If It is inty or o		1 ☐ Burial 2X☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)			y Cremat		23/2004	Sykesvi	lle,	MD		
Baltimore,	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service License	Sartler		Name and Address 11802 Li		Hartzler F	uneral tytown,	Home MD 2	1762		
			23a. Part1. Enter the disease, or compli	cations that saused the deat				·			Approximate		
-	nysician i	w J	shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.	10/11/10	105/21	aLCH6	ST ANDL	CETIB		nterval Between Onset and Death		
2	/Medical		disease or condition resulting in death)	Due to (or as a conseq		(2)	of circ.	SI NADL	act i br	7			
E	Examiner		Sequentially list conditions.										
7	25 to	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	juence of).								
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/60		caiE		L									
	ng phy								- P. C.				
Rox	ine law requires trial the death Settilica tte has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	23b. was decedent pregnant	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta		Ectopic pregnanc	av.			of delivery			
o i	by the att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of d 9☐ Unknown		Other (specify)	,		Mon	th L	ay Year		
ت ا	d by t	Phy	Part II. Other significant conditions cor	tributing to death but not res	ulting in the u	nderhving cause gr	ven in Part I	23e Did to	bacco use contri	bute to the	cause of death?		
ecords,	w requires man been signed to should be deta	d by	Tall II. Outor organization out	and a death parties to	iditing in the di	ndonying ozdase gr	voi iii aiti.	1 🗆 Y	1-2		oly 4 Unknown		
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E E	ate has	Completed						autop perfor	sy pr med? de	ior to comp eath?	oletion of cause of		
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> :	nysician: this certitic al director,	To B	examiner? 1 🗗 Yes 2 🗌 No	ospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Ot		g Home 5 ☐ Resid		r (Specify)	at scene		
ם ס	h. After th funeral		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	irk?		ow injury occurre		Dal 116		
SIO	death. ctor: A y the fa	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At he	2315		Yes 2 No		treet and Numbe				
Division	atter Dirac I in by	Certification:	4 Homicide determined	building, etc. (Specif	(y)			City or Tow	n, State)	1 Bu	KEYSTUWN		
	prospites or Attanding Projection: 24 hours after death, 5 Envaral Director: After this certific stely tilled in by the funeral director,		29a. Certifier 1 Certifying Phys	sician: To the best of my kno	owledge, death	occurred at the ti	ime, date and pl	ace, and due to the c	ause(s) and man	ner as stat	ed.		
:	ne Hos in 24 h he Fur pletely	Medical	(Check only 2 Medical Examination)	ner: On the basis of examina and manner stated.	ition and/or in	vestigation, in my	opinion, death o	ccurred at the time, o	late and place, a	nd due to th	ne cause(s)		
	within 24 To the F complete	Σ	29b. Signature and title of certifier			29c. Licens			9d. Date signed				
	WSL		• //	J.M			O.C.M.E.		March 21	L, 200	J4		
	4		30. Name and adaress of person who co	projected cause of death (Item									
	Sta	te	31. Date filed (Month, Day, Year)	2. Register's Signa	TII P	enn Stre	et, Bal	timore, Ma	ryland 2	21201			
¥	Registr			2004 More	J.	Coule							
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Wade Fox 2004 3:08P March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Beverly Healthcare Frederick Frederick 8. Date of Birth (Month, Day, Year) Dec. 25, 1929 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 74 220-30-7739 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Itams 23a or 28a-f show the Medical Examiner must be rediffed at XXYes 2 No Maryland Frederick Director Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 S. Altamont Ave. 21788 U.S.A. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐Yes 2**X** No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Be Completed by White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) retail petroleum truck driver 11 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any jury or other traumatic event, 90 felt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jesse Adolphus Fox Mary Alice Hahn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy V. Fox/ wife 7 S. Altamont Ave. Thurmont, MD 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Blue Ridge Cemetery 4/2/2004 Thurmont, MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licensee athanine (4045, Main St. Woodsboro, MD 21798 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End stage renal disease **Physician** year resulting in death) /Medical Due to (or as a consequence of): Examiner Ischemic cardiomyopathy S uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last years Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Hypertension years Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ding physician Diabetes mellitus Physiclan/Medical years IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Hypothyroidism, hyperlipidemia, hyperparathyroidism, 1 Yes 2X No 3 Probably 4 Unknown Certification: To Be Completed anemia, immobility syndrome, coronary artery disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 XNatural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of Jertifier 29c. License number 29d. Date signed (Month, Day, Year) D54749 03/30/2004 30. Name and address of person who completed cause of death (I)em 23a) (Type, Print) 30 North Place Allen Reilly Frederick, MD 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

State Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 2001. 12241 For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Faulkner March 30° 2004° ar **Physician** Sally 6:20A. Harney /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Manor Care If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 26, 1939 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🖳 F 225-50-8360 65 Indiana Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10b. County 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Importants if liem 23a or 28a-f show any njury or other traumatic event, if a Medical Examination must be notified at any njury or other traumatic event, if a Medical Examination must be notified at or 28a-f show 1 ☐ Yes 2 ☐ No Maryland Prince George's Beltsville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20705 3623 Dunnington Road United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 1-4 Elementary/Secondary (0-12) Training Officer N.S.A. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James Selby Harney Gladys Imogene Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Thurston U. Faulkner -husband 3623 Dunnington Road Beltsville, Maryland 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) injury or 6 4/4/2004 Davis Cemetery Shipman, Virginia Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service Licenses DUCE. U 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lung Cancer with Metastasis **Physician** 3 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events Due to (u. as a consequence of). Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 2 Fetal death 3 Ectopic pregnancy for Month Day Year 4□Pregnant at time of death 5 Other (specify) should be detached the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☑ Unknown Respiratory Failure 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 2 M No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 □Other (Specify) Medical Certification; To 3 DOA 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred in by the funeral 27. Manner of Death Division Injury 1 Matural 5 Pending To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Att 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title March 31, 2004 30. Name and address of person and John Margolis,

DHMH 17 Rev 1/2001

State

Registrar

13952 Baltimore Avenue Laurel, Maryland 20707

porter

inpleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.

31. Date filed (Month, 'Day, Year)

APR 02

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** MARCH 24, 10:55 PM 2004 STELLA FENTON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY HEBREW HOME OF GREATER WASHINGTON ROCKVILLE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 💢 F 86 052-05-6968 12/25/1917 NEW YORK Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is merked other than "natural, or itams 23a or 28a-1 show eny injury or other traumatic event, the Medical Examinar must be notified at educa. 1 XYes 2 No Director MARYLAND MONTGOMERY ROCKVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6121 MONTROSE ROAD 20852 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No WHITE Baltimore, Maryland 21215-0036 Specify: Specify: à 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) INTERIOR DECORATOR DECORATING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ROSE "UNASCERTAINABLE" SAMUEL WEINSTEIN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) JEROLD N. FENTON/SON 1147 S.E. ARABIAN ROAD, BRANFORD, FLORIDA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 2004 1 ☐ Burial 2X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) MT. COMFORT CREMATORY MARCH 30, ALEXANDRIA, VIRGINIA 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Onset and Death Immediate Cause (Final disease or condition resulting in death) Mocaro **Physician** /Medical as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician a d be detached for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐No 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ should be 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy this certificate 1 Yes 21 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ No 1 🗌 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ☐ ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b Signature and Nittle of certifier 29c. License numbe death (Hem 23a) (Type, Print) 30. Name and address of pe 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 9 Registrar

		1	For State Registrar	State of Maryla		artment of F			Reg. No.		4 12243
. 300 **	sician	1.	Decedent's Name (First, Middle, Last)	Lieto FEROU	JZ			2. Date of De Month March	Day	Year 2004	3. Time of Death 7:37 P
100 C 1 C 1 C 1 C 1 C 1 C 1 C 1 C 1 C 1	edical iminer	48	a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	or Location of Deat			County of Dea	
July 18	*		Holy Cross Hospita	1			r Spring			Montgom	
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and		-	sual Residence of Decedent 0a. State 10b. County	10c.	City, Town or Lo	ocation					10d. Inside City Limits
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-1 show	Funeral Director	N	Montgome	ery	S il ve	r Spring			10- 02	zen of What C	1 ☐ Yes 2 No
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21215-0036 Id within 72 hours all giene. er than "natural", or	ted t	-	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occup	pation		16b. Ki	nd of Business	/Industry
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Maryland id 2 should be file th and Mental Hy 27 is marked oth	E E	1	9a. Informant's Name/Relationship (Ty) Joseph Ferouz, Sor			ng Address (Street Dunoon Ro					
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Baltimore, Dermit. Pages 1 au Department of Hea mportant: If item	SY E ii	-	* 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License								עו
Department	any ii				- Ī	2. Name and Addre	y Hebrew	Funeral	Home	e, Inc.	00010
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Box 68 leath certificat attending phy	etached for use as the Physician/Med		F FEMALE: 2	3c. If yes, outcome of pre	gnancy					23d. Date of de	livery
Box leath cert attendin	Ciar	1	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq Yes \) 2 \(\subseteq No \)	1 Live birth 2 ☐ F 4 ☐ Pregnant at time of		Ectopic pregnanc Other (specify)	У			Month	Day Year
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ords, P requires that een signed b	0		Part II. Other significant conditions con	tributing to death but not	resulting in the u	inderlying cause gr	ven in Part I.	23e. Did t	obacco u	se contribute t	o the cause of death?
Vital Records, sician: The law requires to certificate has been signed.	should b							1 🗆 '	Yes 2	ŽNo 3∏P	robably 4 Unknown
Becordian requires been	page 2 should							24a. Was		24b. Were a	utopsy findings available completion of cause of
Rec The lav	page Com							perfo	rmed?	death?	·
Vital Ficien: The	Be C	1 2	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o			
of Vita	5 L		1 ☐ Yes 2 ◯XNo	ospital: 1 X Inpatient 2	2 ☐ ER/Outpatie	III JU DON	and the second s	Home 5 Resi	dence (6 □Other (Spe	ecify)
			27. Manner of Death 1 □XNatural 5 □ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	of 28c. Inju	ry at irk?	28d. Describe	how injur	y occurred	
att ::	the fu		2 Accident investigation			M 1	Yes 2□No				
Division or Attending after death. Director: After	ed in by the funera		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp		reet, factory, office		28f. Location (. City or To	Street an wn, State	d Number or R)	lural Route Number,
DIVISIC To the Hospital or Attent within 24 hours after deat To the Funerel Director:	ly filled		29a. Certifier 1 Certifying Phys	sician: To the best of my ner: On the basis of exam	knowledge, dea	th occurred at the t	ime, date and plac	e, and due to the	cause(s)	and manner a	s stated.
he Ho n 24 he Fu	mpletely fill	_	one)	and manner stated.	mation and/of I						
To the within 2	Com		29b. Signature and title of certifier	1/11	0	29c. Licen	se number		29d. Dat	e signed (Mon	th, Day, Year)
(0			Duyust	Jarel		D 00	03645		Marc	ch 29,	2004
ď			30. Name and address (filerson who co					17h •	~	2000	6
			Piyush Patel, M.D			our Ferra	ara Ave.,	wneator	1, MI	2090	υ
Bo	State aistrar		31. Date filed (Month, Day, Year) MAR 3 0 200	32. Registrar's Si	~ B	Anne 1	41				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Rag. No. 2004 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 31,2004 **Physician** 9:30pm March Figueroa Crescencia /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Washington Hagerstown 614 Maryland Avenue If Under 24 Hrs. If Under 1 Year Date of Birth (Month, Day, Year) 6/02/1912 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖫 F Puerto Rico Yrs. 580-42-4667 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Washington Hagerstown 1⊠ Yes 2□No MD Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21740 USA 614 Maryland Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 X Yes 2 □ No Specify: Specify: White ۾ 3 Widowed 4 Divorced Puerto Rican Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 0 pamit. Pages 1 and 2 should be filad Dapartment of Health and Mental Hygis Important: if item 27 is marked other any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Felipe Figueroa Rosalia Melendez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 7 0 5 19a. Informant's Name/Relationship (Type, Print) P.O.Box 2400-175 Aibonito, Puerto Rico Genaro Rivrera Figueroa/Son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Cem.LaPaz De El Senor 4/5/04 Aibonito, PR. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Uconsee PHILIP D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nset and Death **Physician** Severe Protein-Calorie Malautrition Failure to thrive Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner The law requires that the death cartificate be axecuted burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and Division of Vital Records, P.O. Box 68760, Physiclan/Medical the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yas 2 XNo þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) ၉ 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: After i Matural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funarei Director: A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) fillad in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 hor To the Funa complataly fi 29b. Signature and title of certifier cm.D 30. Name and address reperson who completed cause of death (Item 23a) (Type, Print) 1124 Opal Court
JERFY L. COPPECES; M.D. Hagerstown, M

Registrar

31. Date filed (Month, Day, Year)

APR 02

2004

32. Registrar's Signature

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State

Registrar

Ahmed Nawas, M.D. 31. Date filed (Month, Day, Year) MAR 3 0

2004

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32. Registrar's Signature

Registrar

MAR 29

Russell Nelso 04-01939 crn	on	Please Type or Print in Black Indelible In		-	_	e.			
CII		State of Maryland / Department of State of St	of Health and M Of Death	lental Hy	rgiene Reg. No. 20	04 1221.			
Physicia	20	1. Decedent's Name (First, Middle, Last)		2. Date of De	Day Y	3. Time of Death			
/Medic		Russell Nelson Freeman, Jr.		March	18 20	04 1:05 P M			
Examin	er		m, or Location of Death		4c. County of Wash	ington			
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye Meeths 2.		8. Date of Bir (Month, Da		Birthplace (State or Foreign Country)			
Director		212-78-0992 IX M 2□F 42 Yrs. Months Da		Octobe	r 12, 1	961 Maryland			
yland yland		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
e Mar	Director	Maryland Washington Hagerstown				1 XYes 2 ☐ No			
with th	Dire	10e. Street and Number 10f. Zip Coo			10g. Citizen of Wha	t Country?			
leath v	Funerai		740 of Hispanic Origin? (Spi	ecify Yes or No	U.S.A.	Americen Indian,			
1215-0036 within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f show the Medical Exaciliner most be recitified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent If Yes, specify 0 11 Yes, 24	of Hispanic Origin? (Spi Cuban, Mexican, Puerto No <i>Specify:</i>	Rican, etc.)	Black, \ Specify:	White, etc. Black			
15-003	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work do life. DO NOT use re	one during most of work	ing	16b. Kind of Busin	ess/Industry			
vithir iene. Ithe M	omo	Elementary/Secondary (0-12) College (1-4or 5+) 12 Plumber	sured)		Plumbing	Contractor			
nd and filed at Hyg	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle	, Maiden Sumame)				
ylai ouid b Ments Ments arked	10	Russell Nelson Freeman	Beverly						
Mar d 2 sh th and th and traum			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 447 E. Franklin St. Hagerstown, Maryland 21740						
re, s 1 an f Heal ftem 2		20a. Method of Disposition 20b. Place of Disposition (Name of	/	Date	20c. Location - City				
Page nent o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crema:		24, 04	Smithsbur	g, Maryland			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mantal Hygiene important: If item 27 is marked other than "natural; or any injury or other treumstic event, the Medical Exercitions.			ddress of Facility Dou tern Blvd.	_	_	neral Home Maryland 21742			
Physician /Medical Examiner	er	23a. Pant. Enter the disease, or complications that caused the dead. Do not enter the mode of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) The immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):		or respiratory a	rrest,	Approximate Interval Between Onset and Death			
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Vision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be exectedeath. To death. To the this certificate has been signed by the attending physicien an by the funeral director, page 2 should be detached for use as the burial-it	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			23d. Date of Month	delivery Day Year			
cords, P	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.			e to the cause of death? Probably 4 Unknown			
Division of Vital Records, for Attending Physician: The law requires that deter death. Director: After this certificate has been signed in by the funeral director, page 2 should be control of the cont	Completed			24a. Was autor perfo	ormed? deat	e autopsy findings available to completion of cause of h? Yes 2 \(\subseteq \text{No} \)			
f Vital F yslcien: Th is certificate director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death Other:						
Of Phys	. To	27 Manner of Death 28a Date of Joint 28h Time of 28c J	4 🗆 Nursing Hor		dence 6 Other (
/ision o Attending Ph r death. sctor: Atter th	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined determined. 28e. Place of Injury At home, farm, street, factory, office.	1 192 2 K 140 P	Oldce put 28f. Location (TSULT Street and Number o	iki g tree during			
Div safte at Dire	Cert	4 ☐ Homicide determined building, etc. (Specify)	ł	1 Wore	ville P	the at Easterday			
Hospital		29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, death occurred at the companient of th	e time, date and place, a	and due to the	cause(s) and manne	r as stated.			
the the	Medicai	one) 25 and manner stated.	ense number		29d. Date signed (M				
or with roo			C.M.E.		March 19,				
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				Man and a second			
15		Tasha Z Greenberg M.D. 111 Penn	Street, Bal	timore	, Maryland	21201			
Sta Registra		31. Date filed (Month Day, Xear) 132 Registrar's Signature Aparlle							

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		For 1 _ State	State of Maryland				Mental Hy	~ ~ ~	0: 10010
		Registrar		Cei	rtificate of	Death	2. Date of De		04 12248
Physic /Medi		1. Decedent's Name (First, Middle, Li	Thomas	Tile			Month	20 h 16	Year 2004 1 03 P M
Examin	er	4a. Facility Name (If not institution, gi				or Location of Deat	h	4c. County o	
		Washington County 5. Social Security Number 6.	y nospital Sex 7. Age (In yrs. Is	ast birthday)	If Under 1 Year	gerstown	8. Dete of Birt	h	ington 9. Birthplace (State or Foreign
Funeral Director			1⊠M 2□F 71	Yrs.	Months Days	s Hours Min.	(Month, De Aug. 8	, 1932	West Virginia
/land		10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
Mar se-f se	ctor	Maryland Washi	ngton	Hag	gerstown				1 Yes 2 XNo
with the 3a or 28	I Dire	10e. Street and Number 17923 Oak Ridge	Drive		10f. Zip Code	21740		10g. Citizen of W US	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any pinyry or other traumatic event, the Medical Examinar must be codified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2⊠ Married	12. Was Decedent Ever in U.S Armed Forces? 1 XYes 2 ☐ No			Hispanic Origin? (S ban, Mexican, Puerl	pecify Yes or No o Rican, etc.)	14. Rece Black	- American Indian, , White, etc.
21215-0036 d within 72 hours at giene. ar than "natural", or the medical Exam.	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1953-	-54	1 Yes 2 X No			Specify:	white
in 72	Completed	15. Decedent's 8 (Specify only highest gi	rade completed)	(Give	kind of work done DO NOT use retire	upation e during most of woi red)	rking	16b. Kind of Bus	siness/industry
d 2121 filed within Hygiene. other then	mo	Elementary/Secondary (0-12)	College (1-4ar 5+)	tele	phone te	echnician		phone	company
of filed all Hygie lother vent,	Be C	17. Father's Name (First, Middle, Las						Maiden Sumame))
should be and Mental a	70	Claude Parson Fi	les ————————————————————————————————————				ildred J		
e, Maryland 1 and 2 should be file Health and Mental Hy tem 27 is marked oth		19a. Informant's Name/Relationship Mary C. Files - v				idge Dr.,			
or Hei		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3		ace of Dispo	osition (Name of matory or other pl.	(ace)	Date	20c. Location - 0	City or Town, State
Pages ment of land: If its		*4 □ Donation 5 □ Other (Spec	ify) Ro	100	11 Cemet		19/04		town, Maryland
Baltimore, permit. Pages 1 a Department of Her Important: If item eny injury or othe once.		21. Signature of Funeral Service Lice	msee Museus		Name and Addi	ress of Facility .1son B1vd		CH FUNERA	
		23a. Part 1. Enter the disease, or con shock, or heart failure. List on	mplications that caused the death yone cause on each fine.	. Do not en	ter the mode of dy	ring, such as cardiad	or respiratory as	rest,	Approximate Intervat Between
Physician		Immediate Cause (Final disease or condition	a Cervical	Tra	cture				Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):	, (`			
A. A. A.	_	Sequentially list conditions, if any, leading to immediate	b. Orgestha	e he	art t	relave			Year
ped nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Chara	CY	the au	muha	dispero		11-865
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O. Box 687 ne death certificate the attending physical control of the steel of the	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnate 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3[Ectopic pregnand Other (specify)	су		23d. Date Mon	of delivery th Day Year
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Records, he law requires to has been signed age 2 should be to	d by						101	es 2□No	3 ☐ Probably 4 ☐Unknown
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f fee	on:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time o	W		28d. Describe h	ow injury occurre	d
Vision Attending or death. ector: After	cat	2 Accident investigati 3 Suicide 6 Could not	be 320 Blood of fairing At he	0100	Pt .	Tyes 2. TNo	281 Location (S	Street and Numbe	r or Rural Route Number,
Division tel or Attending rs after death. al Director: Afte	Certification:	4 Homicide determine	NUPSINC	tome	,		City or Tou	stown	MD
Divisio To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical		Physician: To the best of my know miner: On the basis of examinat and manner stated.						
To th Within To th	Me	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date signed	(Month, Dey, Year)
/x/		1-146	iller AD	D. Ft	E88 14	48804		03 1	7 2004
14,5		30. Name and address of person wh	o completed cause of death (Item	23а) (Туре.	Print)	1	1 1 12	1	
5		Thomas J. Gilb	er LITT Do Wa	shing	ton Cour	ity Hospit	tal lage	rs town;	MD 21740
St Regist	ate rar	31. Date filed (Month, Pay, Year)	32 Hogistrar's Signal	1.0	RIAL				

State of Maryland / Department of Health and Mental Hygiene -Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Year **Physician** 745A M PAIII. ATLEE FINK 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | MAY 26, 1918 5. Social Security Number 6. Sex 1X M 2 □ F 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 85 Yrs. MARYLAND Director 212-14-6479 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-1 ehow other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director ROHRERSVILLE MARYLAND WASHINGTON 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Items 23a 4233 MAIN STREET 21779 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygione. Important: If Item 27 Is marked other than "natural", or Item any injury or other traumatic event. the Madinal Fearthea 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 € No Specify: Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DAIRY FARM 12 FARMER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HELEN MADORA HAINES CLARENCE WILLIAM FINK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4233 MAIN STREET, ROHRERSVILLE, MARYLAND BARBARA L. FINK, WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) MT. OLIVET CEMETERY 4/5/ 2004 FREDERICK, MARYLAND 21. Signatur , J Superal Service Licence 22. Name and Address of Facility 7606 OLD NATIONAL PIKE BAST FUNERAL HOME Zimmerman BOONSBORO, MARYLAND 21713 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatic Dehis. **Physician** carcinomato /Medical Due to (or as a consequence of): Examiner month Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à acetabulums 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed2 2 M No 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death al or Attending F safter death. Il Director: After After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D00265 mo 12 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) MORTHERN HAGERSTOWN 31. Date filed (Mod) 12, Car 2004 32 Registrar's Signature State

Registrar

Deserve

			for State State Registrar	ite of Marylai	nd / De	epartment of F Certificate of	Health and M <i>Death</i>	lental Hyg	giene 200	4 12250
			Decedent's Name (First, Middle, Last)					2. Date of Dea	th	3. Time of Death
	Physici /Medic		SHIRLEY M. GOR	DON				Month 2	Day Year 29 2004	12:05 PM
	Examin		4a. Facility Name (If not institution, give street a	and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	ith
			ATLANTIC GENERAL HOS			BERL			WORCES	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	year) 9. Bi	rthplace (State or Foreign country)
04	Director		221-20-4617 Usual Residence of Decedent	7:	2 ''	5.		8-30-19	931 DE	LAWARE
129/04	/land		10a. State 10b. County	10c. C	ity, Town	or Location				10d. Inside City Limits
2	Man	호	DELAWARE SUSSEX		DAGS	BORO				1 ☐ Yes 2√∑ No
11	in the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
1931	23a unit b	rai	1 SHAWNEE DR. BLACKWA	ATER VILLA		199			US	
San-	er dez	Funeral	Am	is Decedent Ever in U ned Forces?	J.S.	 Was Decedent of H If Yes, specify Cubi 	Hispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
36 0 36	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jical Exactiner must be notified at	by F	If Y]Yes 2 ⊠ No ′es, Give ar or Dates:		1□Yes 2🌠 No	Specify:		Specify:	WHITE
8/30 5-0036	thou stura	ed	15. Decedent's Education		16a. D	ecedent's Usual Occup	pation		16b. Kind of Business	/Industry
215	within 72 ene. then "na	piet	(Specify only highest grade comp	ilege (1-4or 5+)	(0	Give kind of work done ife. DO NOT use retire	during most of worki	ng		
7	d with	Completed	Ziomonia, y, coccida, y (c +2,	2	BOOI	KKEEPER & 7	CAX EXAMIN	ER	STATE OF D	ELAWARE
no.	be filed htal Hygie of other	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			
Year	should ind Men s marke umatic	2	PAUL B. MCCABE		100			CCA LOG		
Shirley 1	nd 2 should be filed withir aith and Mental Hygiene. 27 Is merked other then r treumatic event, tre M		19a. Informant's Name/Relationship (Type, Pri			Mailing Address (Street				Zip Code)
40	E P E B		BECKY BRASURE / DAUGHT 20a. Method of Disposition	20b.	Place of D	#2 BOX 104E			20c. Location - City or	Town, State
NO -	Pages nent of I int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	I from State MA	RINE	RETHEL		,		
Cordon, 221-2 Baltimore,	permit. Pages Department of Himportent: If ite any injury or of once.	1	21. Sign, ture of Funeral Service Licensee	/ CE	METE	22. Name and Addre	3-7-0 ess of Facility		OCEAN VIEW	• DELAWARE
3 8	Deg and Constitution		1 that is luck	w	- 3	MELSON FUN WEST AVE,				
			23a. Part1 Enter the disease, or complications shock, or heart failure. List only one caus	s that caused the dea se on each line.	th. Do no	t enter the mode of dyir	ng, such as cardiac o	r respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Sevsis						Onset and Death
	/Medical Examiner		resulting in death)	Due to lo as a conse	quence of)	i_				
$\sqrt{}$	Zamilei	<u>.</u>	Sequentially list conditions, b.	neun Due to (or as a conse	Section Continues to the					
	rted	ulne	Cause (Disease or injury	345 (5 (5) 45 4 5 5 6 5 6	4401100 01)					
Ć.	execu n and ial-tra	Examiner	that initiated events	Due to (or as a conse	quence of)	:				
68760,	ficate be execute physician and s the burial-trans	edicai	d							
	death certificate b s attending physic of for use as the b	Med	IF FEMALE:							
Вох	ath ce ttendi or use	an/M	23b. Was decedent pregnant 123c. If y	es, outcome of pregn Live birth 2 Fet	al death	3 □Ectopic pregnancy	<i>y</i>		23d. Date of de Month	livery Day Year
	it the dea by the a tached fo	Physicia	1 Vac 2 Mia	Pregnant at time of a Unknown	death	5 Other (specify)			Wichtin	Day Toal
P.O.	that the	Ph.	Part II. Other significant conditions contributing	ng to death but not re	sulting in th	he underlying cause giv	ren in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
ds,	uires that signed t id be det	d by				, , ,		1 □ Ye		robably 4 []Unknown
ō	w requires been s	Completed						24a. Was a	n 24b-Were a	utopsy findings available
Be	The lav te has age 2	отр						autops perform	ned? death?	utopsy findings available completion of cause of
ital	yeicien: The is certificate h director, page	0	25. Was case referred to medical				26. Place of Death			20110
~	nyeic nis ce I direc	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital	i: 1 Inpatient 2] ER/Outpa	atient 3 DOA Cth	er: 4 ☐ Nursing Hon	ne 5 🗆 Reside	ance 6 Other (Spe	city)
0	ding Ph h. After th funeral		27. Mann of Death 28a.	. Date of Injury (Month, Day Year)	28b. Tim Inju	ıry Wor		8d. Describe ho	w injury occurred	
sio	tend death tor: A	cat	2 Accident investigation 3 Suicide 6 Could not be	Disease their Ath			Yes 2 □No	106 Lanation (Ct		
Division of Vital Records,	t or A	ertification:	4 Homicide determined	building, etc. (Speci	ify)	, street, factory, office	-	City or Town	reet and Number or Ri r, State)	urai Houte Number,
_	spitel	O	29a. Certifier 1 Certifying Physician:	To the best of my kn	owledge, d	death occurred at the tir	ne, date and place, a	and due to the ca	ause(s) and manner as	s stated.
	To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	(Check only 2 Medical Examiner: Dr	n the basis of examinated manner stated.	ation and/o	or investigation, in my o	pinion, death occurre	ed at the time, da	ate and place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. Licens	£		9d. Date signed (Mont	h, Day, Year)
						DS.	3612	_ (7129104	
4	81 12		30. Name and address of person who complete	ed cause of death (Ite	m 23a) (T)	po. Print) ea Hh way	Dr R.	-lui in	10 718/	
	Sta	te	31. Date filed (Month, Day, Year) MAR 0 3 2004	32. Pygistrar's Sign	ature [- CIIII Way	7 100 100	ich fo	4011	
	Registr		MAR 0 3 2004	Meseur	J.	Sparke				

			* *	e of Maryland / Depa	artment of Health and crificate of Death		e	12251
	Physici		Decedent's Name (First, Middle, Last)	MICHAEL GEISBE	RT, III	2. Date of Death	2004	3. Time of Death 6:30 P M
	Examin		4a. Facility Name (If not institution, give street and 10612 Highland School		4b. City, Town, or Location of Dea Myersville		c. County of Death Frederick	
ķī	Funeral Director		5. Social Security Number 6. Sex 1X M 2	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year If Under 24 Hr Months Days Hours Mir		9. Birthn Gou Mary	place (State or Foreign ntry) 7 Land
9500-c1	be filed within 72 hours after death with the Maryland in the Harylane. It has "netural, or items 23a or 28s-f show or the than "netural, or items 23a or 28s-f show event, the Medical Examine in that he notified at	ed by Funeral Director	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 1 Never Married 15. Decedent's Education	Decedent Ever in U.S. d5 Forces? /es 25 No s, Give A or Dates:	1e 10f. Zip Code 21773 Was Decedent of Hispanic Origin? (f Yes, specify Cuban, Mexican, Puel 1 Yes 2 No Specify:	Specify Yes or No- rto Rican, etc.)	U.S.A	can Indian, etc.
yland 21215	D 2 2 0	To Be Completed	(Specify only highest grade comple	(Give	kind of work done during most of wo DO NOT use retired) 18. Mother's Na Ruth	orking ame (First, Middle, Maide Horman	on Sumame)	
, Mar	s 1 and 2 shou of Health and M item 27 Is man other traumat		19a. Informant's Name/Relationship (Type, Print, Kerri Korrell (Daughte	r) 6708 I	g Address (Street and Number or F Mountaindale, Roa	d, Thurmont,	, Marylan	d 21788
Saltimore	permit. Pages 1 Department of H Importent: If ite any injury or otl once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal f 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeyal Service ☐ Assec	Mt, Beth	el Cemetery 4/7	/04 Foxy	Location - City or To	ryland
n D	Depa Depa Impo any i		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause	120	Name and Address of Facility BERT E. DAILEY & D1 NORTH MARKET	SI., FREDERI	HOMES, 1	P.A. 1701 Approximate
/on,	Physician /Medical Examiner per period of the priod of t	Ilcal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.	Possible () e to (or as a consequence of): Omicke - Kon e to (or as a consequence of):	Repeation Pre Sakoff synd The lung			Interval Between Onset and Death
O. Box 68	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Medi	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
ecords, P	requires that the een signed by th nould be detache	by	Part II. Other significent conditions contributing Come nay Outer	to death but not resulting in the un	ndertying cause given in Part I.		use contribute to the	he cause of death?
Y	The la ate has page 2	Completed	alional abus	uctive lung	disease	24a. Was an autopsy performed?	prior to cor death?	psy findings available mpletion of cause of 2 2 No
N I I I	yeician: This certificate director, pag	Be	25. Was case referred to medical examiner? Hospital:			ath (Check only one)		
TO UC	ding Phye I. After this funeral di	ation; To	27. Manner of Death 28a. D	1 Inpatient 2 ER/Outpatien Date of Injury Month, Day Year) 28b. Time of Injury Injury	28c. Injury at Work? M 1 Yes 2 No	Home 5 Presidence 28d. Describe how inju		1)
DIVISION	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Certification;	3 Suicide 6 Could not be 28e. P	Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Street a. City or Town, Stat	nd Number or Rura e)	I Route Number,
	he Hospi in 24 hour he Funer pletely fill	edical	(Check only 2 Medical Examiner: On the	o the best of my knowledge, death he basis of examination and/or inv manner stated.	occurred at the time, date and plac restigation, in my opinion, death occ	e, and due to the cause(s urred at the time, date an	and manner as st d place, and due to	ated. the cause(s)
	To the within To the compl	W	29b. Signature and title of certifier Hoffe Mil	,	29c. License number 2005 46 3		ate signed (Month, I	Day, Year) 2004
	· ·		30. Name and address of person who completed Dr. Syed W. Hague 31. Date filed (Month, Day, Year)	100 Montclair		rederick	Md.2	1701
	⇒ Sta Registr		APR 0 6 2004	32. Registrar's Signature	sparks			

			For State Registrar	State of Maryla	•	artment of F			iene •g. No.20	04 12252
Ē	Physicia /Medic		1. Decedent's Name (First, Middle, La Le Moyne	Fairfax	Go	e		2. Date of Dea Month	Day	Year 11:25 pm
	Examin		4a. Fecility Name (If not institution, giv	e street and number)	Unch		or Location of Deat	n	4c. County	of Deeth Crick
			Fredevick 5. Social Security Number 6. S	ex. 7. Age (In vr.	s. last birthday)	Frede		8. Date of Birth		9. Birthplace (State or Foreign
	Funeral Director		211 - 07 - 1628 Usual Residence of Decedent	ØM 2□F 89		Months Days	Hours Min.	8. Date of Birth (Month, Day	Year) 5	Country) Pa.
	Maryland f show	or	10a. State 10b. County		City, Town or La					10d. Inside City Limits 1 ✓ Yes 2 ☐ No
	er death with the Maryland tems 23a or 28a-f show er munt Le trottffed ≝l	by Funeral Director	10a Street and Number	44 Squits		10f. Zip Code 2.1	701	1	0g. Citizen of V	
	ms 23	erai	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of h	Hispanic Origin? (S	pecify Yes or No-	14. Rac	e - American Indian,
9	or its	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	an, Mexican, Puerl Specify:	o Rican, etc.)	Specify	y: Black
5-003	72 hours "natural", dicul En	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece (Give	dent's Usual Occup	pation during most of world)	rking		usiness/Industry
2	within ane. then	jdurc	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire 1 <i>1 CI Q N</i>	d)		Fanchi	tnes
Maryland 2	be filed ntal Hygi ed other avent, I	Be	17. Father's Name (First, Middle, Last	Goe	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			me (First, Middle, i	Maiden Sumam	
37	d 2 should th and Mer t7 is marke traumatic	ဥ	19a. Informant's Name/Relationship (Type, Print)			and Number or Ru	ıral Route Numbei	, City or Town,	
	and 2 Balth a n 27 is			ice (son)			AU Sant			h Md 21701
altimore,	Pages 1 and nent of Healt int: If item 2 iry or other		20a. Method of Disposition 1	Removal from State	cemetery, cre-	osition (Name of matory or other pla	ce) April			City or Town, State
Balti	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Lice		22	2. Name and Addre	ess of Facility Ga Sount ST	PREDLE	ms Fren	level Home
			23a. Perit1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the de	ath. Do not en	ter the mode of dyi	ng, such as cardia	or respiratory arr		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a CVA	,					Onset and Death
Я	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):					
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conse	equence of):					
_	te be executed ysicien and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cons	equence of):					
3760,	# × 8	icai		d			-			
9 ×	certifica ding ph se as th	/Mec	IF FEMALE:	23c. If yes, outcome of preg	nancy				23d Dat	te of delivery
.О. Вох	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as t	by Physician/Med	23b. Was decedent pregnant in the past 12 □ No 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnanc Other (specify)	у			onth Day Year
<u>α</u>	res that the signed by be detacted	y Ph	Part II. Other significant conditions	contributing to death but not r	esulting in the u	inderlying cause gr	ven in Part I.	23e. Did to	bacco use conti	inbute to the cause of death?
ords	w require been sig should b							1 🗆 Y	es 2X No	3 Probably 4 Unknown
Records,	has be	Completed						24a. Was a autops perfor	sy p	Were autopsy findings available prior to completion of cause of death?
tal	inficate or, pag		25. Was case referred to medical			<u> </u>	26 Place of Dea		No 1	1 ☐ Yes 2 No
Ž	ysicionis cert	To Be	examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA	hac	fome 5 ☐ Reside		er (Specify)
o uo	ing Pt		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day Year)	28b. Time of Injury	Wo	ryat rk?]Yes 2 □No	28d. Describe ho	ow injury occurr	red
Division of Vital	i or Attanding Physician: after death. Director: After this certifica I in by the funeral director, i	Certification;	Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	De Blace of Injury At	home, farm, st]165 2 140	28f. Location (S City or Town		per or Rural Route Number,
Ω	ospita hours ineraf y fillec		29a. Certifier 1 Certifying P	hysician: To the best of my k miner: On the basis of exami	nowledge, deat	h occurred at the ti	me, date and place	e, and due to the curred at the time.	ause(s) and ma	inner as stated. and due to the cause(s)
	To the He within 24 To the Fu	Medical	one) 29b. Signature and title of certaier	and manner stated.		29c. Licens				d (Mgāth, Day, Year)
)	T wi		> Kell	K-Kash	un)D	-13971		4/	104
	5		30. Name and address of person who	completed cause of death (in	tem 23a) (Type	Print)	ick, Mar	10-1	21701	
			Robert & Kgutma 31. Date filed (Month, Day, Year)	2014 32. Registrar's Sig		r. preder	ick, Mar	yland	-101	
	Sta Regist		APP A 6	2004	- 10	100	Ms.			

		For State		ryland / Depa		Health and I	Mental Hyg			1225
		Registrar 1. Decedent's Name (First, Middle, La	st)		Timodio oi	D Gaill	2. Date of Dea	th		3. Time of Death
Physicia	an		D MADELINE	UTZ GARDN	ER		April	Day 2,	2004	12:15 P M
, /Medic Examin		4a. Fecility Name (If not institution, give				or Location of Death	1	4c. County of Death		
Examin	ięi	Homewood at Crum			Frede	rick		Fre	deric	k
Funeral Director		5. Social Security Number 216–10=0360	Sex 7. Age	(In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day Dec • 18	, 1915	9. Birtho Cour Mar	place (State or Foreign ntry) yland
filed within 72 hours after deein win the Maryland Hygiene. Hygiene. Hygiene. They have then "naturel", or lieme 23a or 28a-1 ahow ent, the Madical Examiner must be natilised at	_	Usual Residence of Decedent 10a. State 10b. County Maryland Frederi	ck	10c. City, Town or Lo Freder			•		1	10d. Inside City Limits
Ba-t a	Funeral Director				10f. Zip Code			0g. Citizen of	What Cou	
a or 2	Dir	10e. Street and Number 7407 Willow Road			217	02			S.A.	,.
ne 23	eral	11. Marital Status	12. Was Decedent B	Ever in U.S. 13.		Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No-	14. Ra	ce - Americ	
f Health and Mental Hygiene. item 27 is marked other then "naturel", or items 23s or 28s-1 show other traumatic event, the Medical Examiner must be nutitived at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ Ye If Yes, Give Year or Dates:	lo l	If Yes, specify Cut 1 ☐ Yes 2 🛣 No		o Rican, etc.)	Spec	ack, White, <i>ify:</i> Wh	etc. ite
nature lectical E	Completed	15. Decedent's E (Specify only highest gr	ade completed)	life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of wor ed)	king	16b. Kind of I	Business/In	dustry
r ther	E O	Elementary/Secondary (0-12)	College (1-4or 5	+)	Homema	ker		0	wn Ho	me
al Hygiene. I other then vent, the Me	BeC	17. Father's Name (First, Middle, Las	")				ne (First, Middle,		ime)	
Aental rked o	To B	George Norman Hol	tz			1	M. Ferg			
ealth and Mental		19a. Informant's Name/Relationship Larry Utz	(Type, Print) (Son)			tand Number or Ru Fountain .				
nent of Healt ont: It item 2 ury or other 1		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		20b. Place of Disponentery, cre Resthaven	matory or other pla			20c. Location	-	own, State aryland
Department of Importent: It it any injury or once.		21. Signature of Funeral Service Lice		of R	Name and Addr OBERT E.	POSS OF FACILITY &	SON FUN	ERAL H	OMES,	P.A.
0 5 a a		Sohert	ricker	6	15 EAST	MAIN ST.,	THURMON	T, MD	21788	Approximate
nysician Medical		23a. Part1. Enter the disease, or cor shock, or hear failure. List ent Immediate Cause (Final disease or condition resulting in death)	a. Rig	a consequence of):		use e	, or respiratory arr	031,		Interval Between Onset and Death
xaminer	Ļ	Sequentially list conditions,	b	a consequence of						
ysicien and e burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):						
physicien and s the burial-transit	S S		d							
To the Hospital of Attending Prysicien: The Taw requires that the Death Centineate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnan □ Other (specify)	су			ate of deliving	ery Day Year
signed by the a	by	Part II. Other significant conditions			1.1	iven in Part I.	23e. Did to	_		he cause of death?
been sig	ted	Cinencis	Biverill	.culosis	1 7	stugio a)			
ate has b	Completed	Colonic Pol	ps.				24a. Was a autop: perfor	sv	prior to co death? 1 \(\text{Yes}	opsy findings available or of cause of 2 No
certificate rector, pag	Be (25. Was case referred to medical examiner?					ath (Check only or	10)		
this c	9	1 Yes 2 No		ent 2 ER/Outpatie	ent 3 DOA		lome 5 □ Resid			fy)
After 1	on:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year) Injury	l w	ury at ork? _Yes 2 ☑f√no	28d. Describe h	ow injury occi	urrea	
no the mospiter of attending rupercent. The within 24 Hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification;	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Inj	ury - At home, farm, s c. (Specify)	treet, factory, office		City or Tow	n, State)	nber or Run	al Route Number,
spitel of nours a nour			Physician: To the best		th occurred at the			ause(s) and r		
n 24 l se Fu	edical	(Check only 2 Medical Extended)	aminer: On the basis o and manner st		rivestigation, in my	opinion, death occi				
To the To the Comp	Me	29b. Signature and title of certifier	1		29c. Licer	nse number		29d. Date sign		
2		30. Name and address of person wh	completed cause of c	death (Item 23a) (Type		10 Y				21701
		Andrew Z 31. Date filed (Month, Day, Year)	ASCUCK (Tr. M	15 We	st /	st. tre	derid	CM	121/01
St Regist	tate	31. Date filed (Month, Day, Year)	7 2004 b	20 Signature	A 1	sa da				

T.O.D. 12:15 pm

h0-2-h 0.0.0

Known to phypicians as: Mildred m. Gardner

		•	1 - For Amend Item #5 pertain 053 Mas/24/04/Pa	epartment of Health and M Dertificate of Death	lental Hygiene Reg. No. 2	104 12254
	Physicia		1. Decedent's Name (First, Middle, Last) BOSE M. Glover		2. Date of Death Month April	3. Time of Death
>	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. Coun	ty of Deeth
			Pleasant View Horsing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Mt. AIM day) If Under 1 Year If Under 24 Hrs.		9 Birtholece (State or Foreign
	Funeral Director		570 00 0001	Months Days Hours Min.	8. Date of Birth (Month, Day, Yeer) Mar. 9, 1919	9. Birthplece (Stete or Foreign Country) Washington, DC
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	Maryl	tor	Maryland Montgomery Gaithe:	rsburg		1 ☐ Yes 2 🛣 No
	with the	Directo	10e. Street and Number 24109 Woodfield Road	10f. Zip Code 20882	10g. Citizen o	f What Country? Δ
	ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sport Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- 14. Ra	ace - American Indian, leck, White, etc.
36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Health and Mental Hyglene ortant: If item 27 is marked other then "naturel", or Items 23a or 28a-f show ortant: If item 27 is marked other then "naturel", or Items 23a or 28a-f show injury or other traumatte event, the Medical Enginer must be notified at injury or other traumatte event, the Medical Enginer must be notified at a.g.	by Fu	1 Never Married 2 XMarried 1 Yes 2 XNo 1 Yes 2 XNo 1 Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 【X No Specify:	Spec	T 77
21215-0036	72 hour	sted t	15. Decedent's Education 16a. [Decedent's Usual Occupation Give kind of work done during most of work	16b. Kind of	Business/Industry
121	within ane.	Completed	Elementary/Secondary (0-12)	life. DO NOT use retired) Florist	F1o	ra1
2 ام	e filed al Hygid other vent, L	Be Co	17. Father's Name (First, Middle, Last)		(First, Middle, Meiden Suma	
Maryland	a Menta	2	Frederick Wilkerson, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b.	Teres Mailing Address (Street and Number or Rura	a Johnson	n State 7in Code)
<u>¤</u>	alth and 27 Is not traum			4109 Woodfield Road,	-	
altimore,	ges 1 a t of Hea if item or othe		1 Burial 2 Cremation 3 Removal from State	, crematory or other place)		n - City or Town, State
itim m	permit. Pages in Department of Himportant: If ite eny injury or ot once.		'4 □Donation 5 □Other (Specify) Pine (21. Signature of Fugeral Service, Licensee,	Grove Cemetery 04/0		iry, MD eral Home
Ba	permit. Departr Importa eny inji		Jodd Hyu	26401 Ridge Rd., Da		0872
			23a. Pert 1. Enter the disease, or complications the caused the deeth. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ot enter the mode of dying, such as cardiac of	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Myocardial Info			One Day.
	Examiner		Sequentially list conditions, if any, leading to immediate b. Hypertension Due to for as a consequence of			Years.
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	.). 		
,0	certificate be executed nding physician and use as the burial-transit		resulting in death) Last C. Due to (or as a consequence or	():		
68760,	ficate b physic is the b	edica	d			
Box (Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 □Ectopic pregnancy	I	Date of delivery Month Day Year
В	the d	ysici	1 Yes 2 No 9 Unknown 4 Pregnant at time of death	5 Other (specify)		ou, cal
<u>α</u>	Se un ec	by Ph	Part II. Other significent conditions contributing to death but not resulting in Senile Dementia	the underlying cause given in Part I.		entribute to the cause of death?
Vital Records,	nedui		Non Insulin Dependant Diabetes	Mollitus		3 ☐ Probably 4 ☐ Unknown b. Were autopsy findings available
Rec	e la has	Completed	Degenerative Osteo-arthritis	retricus	autopsy performed? 1 ☐ Yes 2 ☑ No	prior to completion of cause of death? 1 Yes 2 No
/ital	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical		(Check only one)	
of	Phys this ral di	. To	1 Yes 2 XNo 1 Inpatient 2 ER/Out 27. Manner of Death 1 Xatural 5 Pending (Month, Day Year)	me of 28c. Injury at	me 5 Residence 6 0 28d. Describe how injury occi	
sion	Attending Indeath.	ation	2 Accident investigation	jury Work? M 1 ☐ Yes 2 ☐ No		
Division	or Attendated after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place ol Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Street and Nun City or Town, State)	nber or Rural Route Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	edical C	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, (Check only one) 2 ★ Medicel Examiner: On the basis of examination and manner stated.			
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number D 30469.		and 2004
,	4		30, Name and address of person who completed cause of death (Item 23a) (1	April	2nd, 2004.
	7		N B Vellanki, MD; 9055 Chevrolet D	rive, #100, Ellicott	City, MD 210	42.
100	Sta Regist		31. Date filed (Month, Day, Year) APR 0 6 2004 32. Registrar's Signature	& Sportal		
			THE Y U LOUT	- The state of the		

ORIGINAL

				State of Maryland / Dep			ene
			For State Registrar	Ce	ertificate of Death		g. No.2004 12255
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) HENRIETTA	Grifi		2. Date of Death Month March	25 2004 9:50 PM
	Examin	er	4a. Facility Name (If not institution, give st		4b. City, Town, or Location of Death	h	4c. County of Death Freclevick
	8		Frederich Mems 5. Social Security Number 6. Sex		Frecherick y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	
	Funeral Director		231 - 30 - 1806	M 201 F 80 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, DEC, 26,	Year) 9. Birthplace (State or Foreign Country) 1923 VI79171A
	yland		10a. State 10b. County	10c. City, Town or			10d. Inside City Limits
	e Mar	ctor	Md. Frederic	ck Freder	ick		1 Yes 2 No
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or Itams 23s or 28s-f show other traumatic event, tra Medical Examinar must be notified at	Funeral Director	10e. Street and Number 610 West Pat	rick St. Apt 7	101. Zip Code 21701	10	g. Citizen of What Country?
	ams arm	ıner	11. Marital Status	Was Decedent Ever in U.S. 13 Armed Forces?	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	irs afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Black
21215-0036	2 hou	Completed	15. Decedent's Educ (Specify only highest grade	ation 16a. Dec	edent's Usual Occupation ve kind of work done during most of wor	rking 1	6b. Kind of Business/Industry
215	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	. DO NOT use retired)	1	PRIVATE
	filed wi Hygien ther th		12th	DOI	n ESTIC		FAMILIES
Maryland	2 should be filed within and Mental Hygiene. Is marked other then surnatic event, the Ms	Be	James Arnold	Spencer Robert		ne (First, Middle, M Theis B	
Ž	should nd Men marks umartic	ပ္	19a. Informant's Name/Relationship (Typ		iling Address (Street and Number or Ru		
<u>≅</u>	ith an 27 is r trau		Robert L. Grifi				1 Fred. Md. 21701
Je,	of Health of Health fitem 27		20a. Method of Disposition	20b. Place of Dis	position (Name of rematory or other place)		Oc. Location - City or Town, State
Ē	Page nent o ant: If		1 Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	FairView		31, 2004 P	rederick Md.
Baltimore	permit. Pages 1 and Department of Health Important: If item 27 eny injury or other to once.		21. Signature of Funeral Service License	9	22. Name and Address of Facility, - Sary L. Adllins Fun O West Sculp St	eval Hom	18 m/ 2.00
	<u>00</u> = 0		23a. Pert1. Enter the disease, or complic	lis	O West South St	Frederich	st. Approximate
	Physician		shock, or heart failure. Ust only on Immediate Cause (Final disease or condition	e cause on each line.	RAL INSUFFIC	JENCY	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	EARLY DISEAS	\$ /	3 YRS
	st Bd	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	2/10/15		
	be executed ician and burial-transit	хап	that initiated events c. resulting in death) Last	Due to (or as a consequence of):	VICE	CIGIA	,
760	e be execu- sician and e burial-trai	calE	L _a	CHRONIC REA	IAL INSUFFIC	4 EN CY	
68	tificate ig phy as the						
P.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		B ☐ Ectopic pregnancy Diagram Other (specify)		23d. Date of delivery Month Day Year
	that the	y Ph	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
of Vital Records,	quires n sign uld be	q pe	PAGETS DIS	EASE of BO	V.G	1 ☐ Yes	2 No 3 Probably 4 Unknown
S	aw requir s been si 2 should	plete	CONGESTIVE	HEART FAILL	RE	24e. Was an	24b. Were autopsy findings available prior to completion of cause of
R	The late ha	mo	HYPERTENSIC	ON		autopsy perform 1 Yes 2	
ita	sian: artifica ctor, I	Bec	25. Was case referred to medical examiner?		26. Place of Dea	ath (Check only one	
>	Physician: this certific ral director,	2	1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ➤ R/Outpat			nce 6 Other (Specify)
on C	fing F After	lon	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time		28d. Describe how	v injury occurred
Division	Attanding r death. actor: After by the funer	ficat	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm,			eet and Number or Rural Route Number,
Ö	s after al Dire	Certification;	4 Homicide	building, etc. (Specify)		City or Town,	State)
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medicel Examin	icien: To the best of my knowledge, de ler: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occurred.	a, and due to the car arred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
	To th withir To th comp	×	29b. Signature and title of certifier	11-5 100	29c. License number	29	d. Date signed (Month, Day, Year)
	-		Dichard #	- yew, wo	111110		03/31/07
	5		30. Name and address of person who con RICHARD G. YERO	N, MD 186 THO	MAS JOHNSON DA	K. #203, FI	REDERICK, MD 21702
*.	Sta		31. Date filed (Month Day, Year) APR 0 5 200	32. Registrar's Signature	Sporks		

			1 1003			partment of F			iene	
			For State Registrar	Glate of N	•	ertificate of			eg. No. 2001	12256
			Decedent's Name (First, Middle,	Last)				2. Date of Dea	th	3. Time of Death
	Physicia /Medic		GEORGE		GLACKEN	I		MARCH 2	Day Year 23 2004	3:33a M
	Examin		4a. Facility Name (If not institution,	give street and number			r Location of Dea	th	4c. County of Dea	
			Frederick Me				erick		Frederi	.ck
	Funeral			5. Sex 7. A 1 1 M 2 □ F	ge (In yrs. last birthd 6.2 Yrs	Months Davs	If Under 24 Hrs Hours Min	. (Month, Day	Year) 9. Bi	rthplace (State or Foreign ountry)
	Director		215-40-1111 Usual Residence of Decedent		62 113			7/27/	1941 MA	RYLAND
	/land		10a. State 10b. County		10c. City, Town o	Location				10d. Inside City Limits
	Man a-f sh	tor	MD. CARR	OLL	WEST	MINSTER				1 X Yes 2 □ No
	or 28)ire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	ath wi	ral	318 CHURCH CO			211			USA	
	er de: Items	Funeral Director	11. Marital Status 1 □ Never Married 2 Marrie	12. Was Deceden	t Ever in U.S.	 Was Decedent of H If Yes, specify Cuba 	lispanic Origin? (S an, Mexican, Puel	Specify Yes or No- no Rican, etc.)	14. Race - Am Black, Wh	
36	rs aft	by F	3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 ፟∆ If Yes, Give Year or Dates		1 ☐ Yes 2 🛣 No	Specify:		Specify: W]	HITE
ò	o filed within 72 hours after death with the Maryland Orlygiene. Orlygiene netural, or Items 23e or 28e-f show yent. Ite M. Jical Ext. after must be neithed.	ted	15. Decedent's	Education	16a. De	cedent's Usual Occup	pation		16b. Kind of Business	s/Industry
215	hin 7.	ple	(Specify only highest Elementary/Secondary (0-12)	Gollege (1-4or		ive kind of work done e. DO NOT use retired	during most of wo d)	orking		
7	73 75 1	Completed	10			MAINTI			EDUCATION	DM
nd	tal H d oth	Be	17. Father's Name (First, Middle, La	ast) AMES M. GI	E A CIZENI			me (First, Middle, I		
7	should be nd Menta i marked umatic av	1º				ailing Address (Ctrast			LOOKINGE	
Maryland 21215-0036	iges 1 and 2 should be filed it of Health and Mental Hyg If itam 27 is marked otha or other traumatic avant,		19a. Informant's Name/Relationshi KAY L. GLACKE			ailing Address (Street CHURCH (
	Heal Heal tam 2		20a. Method of Disposition	7,11	20b. Place of Di	sposition (Name of			20c. Location - City o	
٦	2 2 2 2		t Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe		ST. PAU	crematory or other place L's CEME	TERY 3/	/26/04	UNIONTOW	N. MD.
Baltimore,		l Y	21. Signature of Funeral Service Li						FUNERAL	
ä	Dep Impo any ir		N III							MD. 21157
ñ.	*		23a. Part 1. Enter the disease, or c shock, of heart failure. List of	omplications that cause nly one cause on each	ed the death. Do not line.	enter the mode of dyir	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between
瞾	Pnysician :	E 10	Immediate Cause (Final disease or condition			ENEBRO L				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):					T. 11 ATC 1
	LAGITIMICI	<u></u>	Sequentially list conditions,	ANTERIS	SCIENOT s a consequence of:	16 EARDI	DUASCULA	v Dile	ASE	10 4 FAT 1
	nsit ,	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			nelli Tu				10 4 FAM.
.	te be executed ysician and e burial-transit	Examin	that initiated events resulting in death) Last	0.	s a consequence of):					
760	± > ±	cal		d						
99	The law requires that the death certificate tte has been signed by the attending physicage 2 should be detached for use as the case.	Med	IF FEMALE:							
Box	th ce tendi	an/N	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pregnancy	,		23d. Date of de Month	livery Day Year
-	the at	Physician/M	1 Yes 2 No	4□Pregnant 9□Unknown	at time of death	5 Other (specify)				22,
P.0	that the		Part II. Other significant condition	s contributing to death	but not resulting in th	e underlying cause giv	en in Part I.	23e. Did tol	pacco use contribute t	o the cause of death?
Vital Records,	uires sign	d by	- HYPERT	LEPSION				1 1 1 Ye	s 2 No 3 P	robably 4 Unknown
00	w require been si should b	Completed	STROL	(E (A) 1	temis	PHERE		24a. Wasa		utopsy findings available
Re	The lav	omp						autops perform	ned? prior to death?	completion of cause of
ita		BeC	25. Was case referred to medical	1			26. Place of De	ath (Check only on		2 125 110
of V	di is	ToE	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpat		tient 3 DOA Oth	er: 4 🗆 Nursing I	Home 5□Reside	ence 6 Other (Spe	ecify)
n o		lon:	27. Manner of Death 1 ■ Natural 5 □ Pending		jury 28b. Tim lay Year) Inju	y Wor	k?	28d. Describe ho	w injury occurred	
sio	tan leat tor: the	icat	2 Accident investigation inves	ot be One Place of the	njury - At home, farm		Yes 2 □ No	28f Location (St	reet and Number or R	um I Route Number
Division	after death	Certification;	4 Homicide determin	building,	etc. (Specify)	Street, factory, office		City or Town	, State)	Brai i lobie i lamoor,
	a Hospital or 24 hours affe a Funaral Dir etely filled in		29a. Certifier 1 Certifying	Physician: To the bes	t of my knowledge, d	eath occurred at the tir	ne, date and plac	e, and due to the ca	ause(s) and manner a	s stated.
	To tha Hospital or At within 24 hours after of To tha Funaral Direct completely filled in by	Medical	(Check only 2 Medical E	xaminer: Off the basis and manner s	of examination and/o	r investigation, in my o	pinion, death occ	urred at the time, di	ate and place, and du	e to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of ce tifier			29c. Licens		2	9d. Date signed (Mon.	
,,	MARK		1	MU PM	>	D -3	319112		3/23/	7
	A 6		30. Name and address of person w				Car	60/114	mp 217	02
	Sta	to	31. Date filed (Month, Day, Year)	32. Regi	frar's Signature	ows hin	, rren	EIMIN	THY ALL	_
	Registi			5 2004	new &	Souther				

Please Type of Print in Black indelible ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** March 28, 2004 9:08am Alexander William Goode, Jr. /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Prince George Prince George Hospital Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10X M 2 □ F April 25, 1942 North Carolina 61 243-64-0546 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rel', or Itams 23a or 28a-f show Examiner : ust be notified at 1X Yes 2 ☐ No Mitchellville Maryland Prince George Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20721 United States 2508 Myer Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No "naturel", or Itams 11. Marital Status 1 ☐ Never Married 2 A Married Specify: Black Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) than College (1-4or 5+) Kitchen Distributor Private and Mental Hygiene is marked other the injury or other traumstic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Rogers Alexander W. Goode 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trau Pages 1 and 2 2508 Myer Rd., Mitchellville, MD. 20721 Glendora Davis 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Resurrection Cem. April 2,2004 Clinton, MD. * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Pope Funeral Homes 22. Name and Address of Facility 5538 Marlboro Pike Forestville, MD. 23a. Part1. Enter the isease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC FATAL **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Physician/Medical 38 IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year for 4 Pregnant at time of death 5 Other (specify) ed by the a detached f Division of Vital Records, P.O. 9□ Unknown 9 Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy , page 2 1 Yes 2 No 1 ☐ Yes 2X No : After this certifical funeral director, i or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 1 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No death. investigation 2 Accident Director: filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after To the Hospitel within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20744 BONE 10905 WASHINGTON Haus 31. Date filed (Month, Day, Year) Registrar's Signature State 0 2 2004 Registrar

DHM 5 17 Rev 1/2001

				State of Maryland / De	partment of Health and I	Mental Hyg	giene 2004 1225	Ω
		5 %		1 - State Registrar Amend#27.Per Phys.PGC cr 4-1-04 1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Dea	leg. No.	U
		Physici	an	Pauline D. Gordon		Month j	Day Year 1	м
	1	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	March	28 2004 5:23 ph 4c. County of Death	_
		Examin	er	Doctors Community Hospital	Lanham		Prince George's	
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdo	(ay) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day Apr. 29	9. Birthplace (State or Foreig Country) Wash., DC	gn
		Director		578-20-0450 1□M 2N F 85 Yrs	b. Noticis Days Floors Will.	Apr. 29	, 1918 Wash., DC	
		and ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	r Location		10d. Inside City Limit	s
		Mary -1 sh	tor	Maryland Prince George's	Springdale		1 XYes 2 □ N	0
		h the	irec	10e. Street and Number	10f. Zip Code	1	10g. Citizen of What Country?	
2		23a c	ral	9209 Gary Lane	20774		United States	
nopar		ar dea	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.	
3	36	rs afte	oy F	1 ☐ Never Married 2 [X] Married 1 ☐ Yes 2 [X]No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 XNo Specify:		African American	
	Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. uthar then "natural", or Itams 23a or 28a-1 show ant, the Medical Examinar must be notified at	Completed by Funeral Director	15. Decedent's Education 16a. De	ecedent's Usual Occupation		16b. Kind of Business/Industry	
	215	thin 7 e. an "n	nple	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of wor fe. DO NDT use retired)	King		
0	21	ed wi ygien ygien rar th	Cou	12th	Keypunch Operat		Government	
00	and	be fill Hall Had off	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nan		Maiden Sumame) .e Ware	
Delores	Ë	hould d Mei mark	2	Luther Thornman 19a. Informant's Name/Relationship (Type, Print) 19b. M	lailing Address (Street and Number or Ru			
(-2	Ma	ad 2 s lith an 27 is r trau			9209 Gary Lane, Spr			
1	re,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic evant, the Medical Examiner must be notified at ances.		20a. Method of Disposition 20b. Place of Di cemetery,	isposition (Name of crematory or other place)	Date	20c. Location · City or Town, State	_
Queline	Baltimore,	Page nent c ant: If ury or		Months 2 Chemiston 3 Chemovaliton State	l Veterans Cem. 4/2	/2004	Cheltenham, MD	
3	lait	permit. Departr Importa any inju		21. Signal are of Funeral Service Licenses			uneral Home	
O.	Ш.	20529		John ! Ilwan !!!	4001 Benning Rd			
				23a. Part / Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arr	rest, Approximate Interval Between Onset and Death	
		Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)				
	B	Examiner		Due to (or as a consequence of):	LEFT LEG			
		SO EN	je.	Sequentially list conditions, if any, leading to immediate cause. Lint of Jan, ing Cause (Disease or injury) Due to (or as a consequence of): PERIPH CLA				
		cuted nd ransit	Examiner	that initiated events	L VASCULAR	DISE	TASE	
	760,	le be executed ysician and e burial-transit	E		1:10			
	876	eath certificate be executed attending physician and for use as the burial-transit	dlcal	a RENAL FAI	LUKE			
	9 X	ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
	Bo	ieath atter	ciar	23b. Was decedent pregnant in the past 12 months? 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year	
	0	t the c by the ached	Physician/Med	9 Unknown				
	Division of Vital Records, P.O. Box 68	wrequires that the d been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.		bacco use contribute to the cause of death?	
	ord	equir sen si bluo	ted	HYPERTENSION		1 □ Y	es 2 No 3 Probably 4 Punknow	'n
	ec	law I	Completed by	MALNUTRITION		24a. Was a autops	sy prior to completion of cause of	le
	я н	cate to page	Cor		AILURE	perform 1 🗆 Yes	med? death? 2 No 1 ☐ Yes 2 ☐ No	
	Vit.	ysician: The law is certificate has b director, page 2 s	o Be	25. Was case referred to medical examiner? Hospital:	0.1	ath (Check only or		
	of	Phys sr this sral di		1 ☐ Yes 2 ☑ No ☐ 1 ☑ Inpatient 2 ☐ ER/Outpa 27. Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at		en e 6 Dther (Specify)	
	ion	nding ath. r: Afte e fune	atlo	1 Natural 5 □ Pending (Month, Day Year) Injuing 2 □ Accident investigation	ry Work? M 1 ☐ Yes 2 ☐ No		/	
	N/S	r Atta er deg recto	Certification;	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide	, street, factory, office	28f. Location (treet and Number or Rural Route Number, n, State)	
	ā	ital or irs aft ral Di led in	Cer					
		To the Hospitel or Attending Physicien: The lew requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as th	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, d	leath occurred at the time, date and place or investigation, in my opinion, death occu	e, and due to the corred at the time, d	ause(s) and manner as stated. late and place, and due to the cause(s)	
		o tha o tha omple	Mec	29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Month, Day, Year)	
		FSFÖ		ATTENDING PHYS	14AN D005291	00	03 29 2004	
^ /)	(2)		30. Name and address of person who completed cause of death (Item 23a) (Ty	rpe, Print)			-
4	_	(V)			00 CENTRAL AV	#301,	LANDOVER MD 2018	7
•		Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 0 1 2004	ule			

			1 - For Amend #5 per I	State of Ma	ryland	l / Depai <i>Cert</i>	rtment of I	lealth ai Death	nd Me		giene Rog. No.		L 1	2250
Part of the second	୍ତ Physici	an	1. Decedent's Name (First, Middle, Last)	Compie						. Date of De Month	Day	Yea	3. 1	Time of Death
	/Medic		Santos 4a. Facility Name (If not institution, give s	Garcia			4b. City, Town, o	or Location of		March		200 County of D		:12P M
	Examir	er	Holy Cross Hos				Silve				-	ontgo		•
K.	Funeral Director		5. Social Security Number 6. Sex 517-15-5980 XX			st birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24		Date of Bird (Month, Da 6 – 4 –	y, Year)	9. E E1	Country)	State or Foreign
	Maryland f show	lor	577-15-5980 Usual Residence of Decedent	1	, ,	Town or Local	ation Spring							side City Limits
	h with the 23a or 28a st be notii	al Director	10e. Street and Number 2108 Coleridge	Drive			10f. Zip Code 2091	0				zen of What Salva		
036	d within 72 hours after death with the Maryland Jiene. rthan "natural", or fama 23a or 28e-f show the Madical Examiner rust be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	I2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		lf '	as Decedent of I Yes, specify Cub	an, Mexican,	n? (Specif Puerto Ric	y Yes or No can, etc.)		14. Race - Ai Black, W Specify: T	hite, etc.	
1215-0036	vithin 72 ho ne. han "natur e Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+	-)	(Give ki life. Di	int's Usual Occupind of work done ONOT use retire	during most o				ivate		
Maryland 2	be filed tal Hygi d other	Be	6th 17. Father's Name (First, Middle, Last) Feliciano Pa	alencia		Rese	aurane	18. Mother	s Name (F	First, Middle,	Maiden			
Ž	2 should land Meni ie marker sumatic	To	19a. Informant's Name/Relationship (Typ		-	19b. Mailing	Address (Street	and Number	or Rural F	Route Numbe	or, City o	r Town, State	, Zip Code)
	s 1 and 2 shou f Health and M item 27 ie mer other traumat		Gabriela Garcia,	/Daughte		30 Be	llingh	am St	. Ch	elsea	1, M	ia. 02	2150	
Baitimore,	mit. Pages 1: partment of He portant; if iten r injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ice of Disposi metery, crema NWOOD	tion (Name of atory or other pla	сө)	Date / 29 /	9	20c. Lo	cation - City	or Town, S	tate
Balt	permit. Departr imports any inju		21. Signatur d Funeral Service License	Hacker	t ×	h.	Name and Addre Robert	O. F				al Se	rvic	es
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused to e cause on each line Seps: Due to (or as a	is		the mode of dyl	ng, such as ca	ardiac or re	espfratory af	rest,•		Inten	oximate val Between ot and Death
8/60,	death certificate be executed e attending physicien and of for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a										
280	ificate g physas the	edic	0.	•										_
C. Box	at the death certifica by the attending pt tached for use as ti	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome o 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetal	death 3□E	etopic pregnanc Other (specify)	у			2	3d. Date of d Month	delivery Day	Year
rds, P	w requires that the been signed by the should be detache	by	Part II. Other significant conditions con Deep Venous			ting in the und	lerlying cause giv	ven in Part I.			bacco us	se contribute		se of death?
II Kecord	The law ate has b page 2 st	Completed								24a. Was autop perfor 1 Yes	sy	prior to death	o completic	dings available on of cause of
VItal	Phyalcian: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	ospital:			Ott		- 67	Check only o				
o	Physic this sral di	: To	1 ☐ Yes ≥ CNo 27. Manner of Death	28a. Date of Injury (Month, Day		R/Outpatient 28b. Time of	3⊡ DOA 28c. Injui	4 🗆 Nurs		5 ☐ Resid		Other (Sp	pecify)	
UIVISION	al or Attending F after death. I Director: After d in by the funer	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined	(Month, Day		Injury	M 1	rk? Yes 2⊡No	0			i Number or	Rural Route	e Number.
ź	To the Hospital or Atti within 24 hours after de To the Funeral Directi completely filled in by ti		29a. Certifier Certifying Phys	building, etc.	(Specify) my know	ledge, death o	occurred at the til	me, date and	place, and	City or Tow	n, State)	and manner	as stated.	
	the H the Fu pletel	Medical	one)	and manner state	ed.	on and/of inve			occurred					
	o Viti	×	29b. Signature and title of deriffiel	W			DS	4347				3 signed (Moi 26 - 2		ear)
	1.11			No. C. Cale										

State Registrar

31. Date filed (Month, Day, Year)
MAR 3 0 2004

Neeraj Chopra, M.D. P.O. Box 83819 Gaithersburg, Md. 20883 32. Registrar's Signature

		1 - For State Registrar 1. Decedent's Name (First, Middle, Las	•		artment of rtificate o		2. Date of Death	g. No. 200	3. Time of Death
Physici /Media Examir	cal	Christopher Galla 4a. Fecility Name (If not institution, give	street and number)		4b. City, Town	n, or Location of De	Month 03	Day Year 24 04 4c. County of De	11:16 a.M
Funeral Director		Prince George's H 5. Social Security Number 6. Sr 220-80-2505 1 Usual Residence of Decedent		. last birthday)	Chever If Under 1 Ye Months Day	ar If Under 24 H		Prince 0 9.8 1960 Was	eorge's inthplace (State or Foreigr Country) Shington, DC
r 28a-f show	rector	10a. State 10b. County MD Prince 6		Lando		Ð	10	g. Citizen of What (10d. Inside City Limits 1X Yes 2 No
IL I I I I I I I I I I I I I I I I I I	by Funeral Director	7101 East Spring 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Street 12. Was Decedent Ever in Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		2078 Was Decedent of f Yes, specify C 1 □ Yes 2 ☒ N	of Hispanic Origin? uban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - An Black, Wr Specify: B1	nerican Indian, lite, etc.
Marylatic Z.I.Z.I.5-UU.50 nd 2 should be filed within 72 hours alt th and Mantal Hygiene. 27 is marked other then "neturel", or traumatic event, the Modical Exami	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0·12) 12th	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occ kind of work do DO NOT use ret Gardene	ne during most of w ired)	rorking	6b. Kind of Busines	
Marylatic Z	To Be C	17. Father's Name (First, Middle, Last) James Harold Gal 19a. Informant's Name/Relationship (7)		19b. Maili	ng Address /Stre	Saral	ame (First, Middle, Mana Mille Rural Route Number, (er	Zin Code)
te a de		Sarah Gallmon/ Mo 20a. Method of Disposition 1 Burial 2 Cremation 3	ther 20b.	7101	E. Spri	ng St.	Landover,	MD 20785 Oc. Location - City of	r Town, State
Daltimore, permit. Pages 1 ar Department of Hea Important: if Item eny injury or othe		*4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen) Wa	22		ress of Facility	27/04 S J.B. Jenkin Landoven		1 Home
Fnysician /Medical Examiner		23a. Part 1. Enter the disease, or companions, or heart failure. List only of limediate Cause (Final disease or condition resulting in death)	ne cause on each line.	CQUIRE			ac or respiratory arres	it,	Approximate Interval Between Onset and Death
g physician and as the burial-transit	cal Examiner	Sequentially list conditions, I any leading to inneclate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Una to (or as a consect. Due to (or as a consect.						
death certifica e attending ph d for use as th	Physician/Medi	IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pregnar Other (specify)		11177	23d. Date of de Month	elivery Day Year
- E D -	by	Part II. Other significant conditions of	entributing to death but not re	sulting in the u	nderlying cause	given in Part I.	23e. Did toba	1.0	o the cause of death?
	Completed							prior to death?	utopsy findings available completion of cause of s 2 \sumbox No
Attending Physician: T r death. sctor: After this certificat by the funeral director, pa	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 Inpatient 2) 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. In	Other: 4 🗆 Nursing	eath (Check only one) Home 5 Residence 28d. Describe how		acity)
	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At a building, etc. (Spec	ify)			City or Town, S		
To the Hospital or within 24 hours afte To the Funerel Dir completely filled in	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	valcien: To the best of my kniner: On the basis of examinand manner stated.	owledge, death ation and/or in	estigation, in my	opinion, death occ	curred at the time, date	se(s) and manner a e and place, and du . Date signed (Mon	e to the cause(s)
- (I)		30. Name and address of person who c			Print)	60096		3/25/0	7
Sta Registr		DAVID JACOSS MD 31. Date filed (Month, Day, Year) MAR 2 9 2004	2150 Pennsy 32. Registrar's Sign	ature		, ZB Was	hington, D	L 20008	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Ivid	•	Certificate of			eg. No. 2 1) (nı.	12261
			1. Decedent's Name (First, Middle, L	ast)				2. Dete of Deat	h		3. Time or Death
	Physicia /Medic		Robert L. Grift	Ein					21, 2004	Year	9:47 A
	Examin		4e Fecility Neme (If not institution, g	ive street end number)				Location of Deeth	4c. County o		
			Southern Maryla	-		thday) If Under 1 Yea	Clinton		Princ		
	Funeral Director			1 → M 2 □ F	e (In yrs. lest bir 58	Yrs. Months Day			2, 1945	S. Ca	ace (Stete or Foreign arolina
	ylend		10a. State 10b. County		10c. City, Town					10	d. Inside City Limits
	Mari	ctor	MD Charle	es	Waldo	rf					1∰ Yes 2□ No
	th with the	Funeral Director	10e. Street end Number 2330 Hope Circ	le		10f. Zip Code 20	602	1	0g. Citizen of Wi USA	nat Count	ry?
	r dea	ne.	11. Marital Status	12. Was Decedent I Armed Forces?		13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Race Black	- America White, e	
9036	ours afte ral', or h Examin	To Be Completed by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 N If Yes, Give Year or Dates:	√ 0	1□ Yes 2⊠N			Specify:	Bla	
<u>2</u>	netu	etec	15. Decedent's I (Specify only highest g	Education rade completed)	16e.	Decedent's Usual Occ (Give kind of work don life. DO NOT use reti	upation e during most of wo	orking	16b. Kind of Bus	iness/Indu	ıstry
12	within	dmo	Elementery/Secondary (0-12)	College (1-4or 5	(+)	nstruction			Drvwal	l In	staller
g 5	Hygin Sther ent,	ပိ	17. Father's Neme (First, Middle, Las	it)		A LOCAL CALCALO		me (First, Middle, M			
<u>la</u> n	Ald be fental rked c	OB	William Griffi	n			Lilli	le Simon			
Maryland 21215-0036	alth end Nathernal National Na		19a. Informant's Name/Relationship Margaret Bowen		19b	. Mailing Address (Stre 449 Coc	et and Number or R k Ave, Pa	aulsboro,	City or Town, S NJ 0806		Code)
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil had Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 4 ☐ Department 5 ☐ Other (Special Control of		cemeter	Disposition (Name of y, cremetory or other parties Career		Date 3/27/04	20c. Location - C Clint	•	
Salt	aparti aparti aportu ny Inji		21. Signature of Funeral Service Lips	ensee		22. Name and Add	ress of Facility	Strickla	nd Funer	al S	ervices
ш	70 E 8 9		De D. /X	Man		6500 Alle	ntown Rd	, Camp Sp	rings, M	1D 20	748
			23a. Part1. Enter the disease, or con shock, or heart failure. List onl	mplications that caused y one cause on each lir	the death. Do r	not enter the mode of d	ring, such as cardia	ac or respiratory arre	est,	1	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final	100	1 1		. 1 -	C - 1			Onset and Death
	Examiner		disease or condition resulting in death)	a. NCUT	e fil	10 Cardi	alin	tarch Diseas	00	-	
		Je		CARZ	Due to (or es e	consequence or):	an T	SiRP DE	0	1	
	cuted nd rensit	ami	Sequentially list conditions.	b. 0010	Due to (or as e	consequence of):	10	213073	-		
Ö,	rificata be exacuted ng physician end as tha buriai-trensit	edicai Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	•						İ	
68760,	ata b hysic tha b	dica	that initiated events resulting in death) Last	C	Due to (or as a c	onsequence of):					
9 ×	ding p	Me		l d						1	
Box	aath c atten for u	cian									
o	tha d by the achec	hysi	Part II. Other significent conditions	contributing to death bu	it not resulting in	the underlying cause of	iven in Part I.		baccouse conti es 2□No 3		the cause of death?
S,	s that gned to	by P	knd Stag	e Ker	ral	DISEON	و		98 ZUNO S	o □ Probe	ibiy şı anknown
Division of Vital Records,	The law raquires that the death certificate be executed ate has been signed by the attending physician end pega 2 should be datached for use as the burial-trensit	Completed by Physician/M	Diabetes	Melli	Us			24a. Was ar perform		avail	e autopsy findings lable prior to pletion of cause eath?
ř	The law ste has pega 2	E O						1 ☐ Ye	s 2No	1 🗆	Yes 22 No.
Ita	ilclan: The certificete rector, peç	Be	25. Was case referred to medical examiner?				26. Place of De	ath (Check only one	9)		
5	Physic this ce al dire	2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie		IDAIIEIIL 3LI DOA		Home 5 ☐ Reside	nce 6 Other	(Specify)	
Ž	Attending Physician: or death. ector: After this certific by the funeral director,	ion:	27. Menner of Deeth S Natural 5 Pending	28e. Date of Injur (Month, Day	Year) 28b. T	ime of 28c. Injury W		28d. Describe ho	w injury occurred	d	
Sign	death death ctor: /	licat	2 Accident investigation 3 Suicide 6 Could not	be One Place of lei	rv - At home, fai	rm, street, factory, office]Yes 2 ☐ No	28f. Location (Str	reet and Number	or Rural	Route Number
<u>></u>	after Direction by	Certification:	4 ☐ Homicide determined	building, etc		mi, stroot, lactory, ornor	•	City or Town	, State)	Or Muran	Toute Number,
	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, paga	edicai C	29a. Certifier (Check only one) (Check only one) (Check only one)	hysiclen: To the best of miner: On the basis of end manner sta	exemination end	, death occurred at the d/or investigation, in my	time, date and place opinion, death occ	e, and due to the ce urred at the time, da	use(s) and menr ite and place, an	ner as sta d due to t	ted. he cause(s)
	within To the	Me	29b. Signature end title of certifier			29c. Licer	nse number	29	d. Date signed ((Month, D	ay, Year)
			► V ll			05	53885		3/23	120	104
	(0)		30. Neme end eddress of person who	completed cause of de	eth (Item 23e) (Type, Print)		41 - 1	#307/	3	
	0		VENKAI. S.	KAMA	NAN		Surra	HS Rd	7 (linz	m, ms
	Sta Registr		31. Dete filed (Month, Day, Year) MAR 2 9 2004	32. Registre	or's Signeture	artes				Ö	735

	1 - State of Maryland / De Registrar	epartment of Health and M Certificate of Death	Mental Hygiene 20	04 1226
Physician /Medical	Decedent's Name (First, Middle, Last) Prasanta Kumar Ghosl		March 26, 20	3. Time of Death 004 5:30 P.
Examiner	4a. Facility Name (If not institution, give street and number) Suburban Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birth)	4b. City, Town, or Location of Death Bethesda day) If Under 1 Year If Under 24 Hrs.		tgomery
Funeral Director	073-48-5024 1 3 M 2□ F 71 Yr	Months Days Hours Min.	(Month, Day, Year) Nov. 15, 1932	9. Birthplace (State or Foreig Country) India
fied at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of Decedent Maryland Montgomery Bet	or Location Chesda		10d. Inside City Limi 1 ☐ Yes 2 🛣 N
a or 282 be not	10e, Street and Number	10f. Zip Code	10g. Citizen of Wh	at Country?
Department of Health and Mental Hygenes Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show and in the marked and itema 200. To Be Completed by Funeral Director	8733 Ridge Road 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	20817 13. Was Decedent of Hispanic Origin? (Sr. If Yes, specify Cuban, Mexican, Puerto		American Indian, White, etc. White
t, the Medical E.		Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)	16b. Kind of Busi	ness/Industry
sed other to event, the	17. Father's Name (First, Middle, Last)	Economist 18. Mother's Nam	e (First, Middle, Maiden Sumame) Puspa Sinha	
s marke aumatic	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. I	Mailing Address (Street and Number or Rui		ate, Zip Code)
If item 27	20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 20b. Place of Cemetery,	crematory or other place)	Date 20c. Location - C	ity or Town, State
mportant: any injury ance.	21 Signature of Funeral Service Licensee	olitan Crematory 3/2 22. Name and Address of Facility DeV 10 East Deer Park D	ol Funeral Home	
physician and it is the burial-transit edical edical examiner): - nonia		Interval Between Onset and Death
the attending hed for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date Monti	,
be det	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contrib	ute to the cause of death?
cate has been significant page 2 should be			autopsy pri performed? de	ore autopsy findings availate or to completion of cause cath? Yes 2 \sum No
certific rector	25. Was case referred to medical examiner?		th <i>(Check only one)</i> ome 5 Residence 6 Other	(Specify)
5 m			28d. Describe how injury occurred	
10 S	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	π, street, factory, office	28f. Location (Street and Number City or Town, State)	or Rural Route Number,
To the Funeral Completely filled	29a. Certifier Certifying Physician: To the best of my knowledge, (Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.	or investigation, in my opinion, death occur	rred at the time, date and place, an	d due to the cause(s)
Tot	29b. Signature and title of certifier	29c. License number H 0051280	29d. Date signed (
V	30. Name and address of person who completed cause of death (tem 23a) (Tanushiravan Dadgar, M.D., 13219 Exc		e, Germantown, M	D. 20874
State Registra		9 Sparks		

			For State	State of M	aryland		artment of <i>rtificate o</i>			Mental Hy	-	2001	100-
			Registrar 1. Decedent's Name (First, Middle, La	ct)		Cei	uncate o	Deal		2. Date of De	Reg. No.	UUU	3 Time of Death
	Physicia	an	Anna Grabows							Month March	Day	Year	7:30pm ^
	/Medic Examin		4a. Facility Name (If not institution, giv)		4b. City, Town	n, or Location	on of Death			County of Deat	
	Examin	e i	Genesis Eldercar				Silver	Spri	ng		Mon	tgomer	У
	Funeral		5. Social Security Number 6. S	ex 7. A	ge (in yrs. las		If Under 1 Yes	ar If Und	ler 24 Hrs.	8. Date of Bir	rth	9. Birt	hplace (State or Foreignston)
	Director		135-52-1884	□M 2X)F	91	Yrs.	Infolitio Ba,	,,,,,,,,,		FEB 9,	"1913	Can	aďá
	and *	}	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limi
	/laryli	ō	Maryland Montgom	oru			pring						1 □ Yes 2 1 1
	28e-	Director	10e. Street and Number	егу	DII	VCI U	10f. Zip Code	е			10g. Citiza	en of What Co	untry?
	3e or	٥	14504 MacBeth Dr	ive			2090	6			Unite	ed Stat	es
	ms 2	by Funerai	11. Marital Status	12. Was Decedent		13.	Was Decedent of	of Hispanic	Origin? (Sp	ecify Yes or No)- 14	4. Race - Ame	
, .	after or fte	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces' 1 ☐ Yes 2X☐ If Yes, Give			f Yes, specify C 1 ☐ Yes 2 🗓 N			Hican, etc.)		Black, White	9, 8tc.
,	ral',	d b	3 X Widowed 4 □ Divorced	Year or Dates:			10163 2041	10 Spec	ny.			Specify: wh:	ite
i	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "netural", or flems 23e or 28e-f show reumetic event, the Marilan Examination and the notified at	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Dece (Give	dent's Usual Oct kind of work do DO NOT use ret	cupation ne during m	ost of work	ring	16b. Kind	d of Business/	Industry
	within ane. then	mp	Elementary/Secondary (0-12)	College (1-4or				urea)			0	77	
	Hygie ther int, II	ပိ	12 17. Father's Name (First, Middle, Last)	1	louse	wite	18. Mo	ther's Nam	e (First, Middle	Own Maiden S		
	d be ental ced o	To Be	(UNKNOWN) Bu	rkovitz				(UI	NKNOW	N)			
	shoul nd M marl	Ė	19a. Informant's Name/Relationship (Type, Print)		19b. Mailie	ng Address (Stre	et and Nun	nber or Rur	al Route Numb	er, City or	Town, State, Z	(ip Code)
	nd 2 alth a 27 is r treu		Norman S. Grabow	sky / Son	1	L4504	MacBetl	h Dr.	Silve	er Spri	ng, M	D 2090	5
	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netur any injury or other treumetic event, tre Musical 2006s.	ĺ	20a. Method of Disposition		1	e of Dispo	sition (Name of natory or other p	olace)	1	Date	20c. Loc	ation - City or	Town, State
	Page Int: I		1 X Burial 2 ☐ Cremation 3 2 `4 ☐ Donation 5 ☐ Other (Specil		• 1		omon Cer		Marcl	n 30, 2004	C1if	ton, N.	J
	permit. Departir Importe any inju		21. Signature of Funeral Service Lice	1See 1	100956		. Name and Add			57 F			
1	89558		fred 1	Me			uis Subu -01 Broa			r Lawn,	NJ 0	7410	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each l	d the death. line.	Do not ent	er the mode of o	tying, such	as cardiac	or respiratory a	rrest,		Approximate Interval Between
4	Tiysician		Immediate Cause (Final disease or condition	a DEMENT	[A								Onset and Death YEARS
	/Medical Examiner		resulting in death)	Due to (or as	s a consequer	nce of):							
	Examiner	_	Sequentially list conditions,	b									
	ed sit	xaminer	if any, leading to immediate cause. Enter Underlying	Due to (or as	s a conseque	nce of):							
	be executed iician and burial-transit	хап	that initiated events resulting in death) Last	cDue to (or as	a consequer	nce of):							
	certificate be ex ding physician ise as the buria	alE											
	icate phys s the	dic		_ d									
400	eath certificate be exattending physician for use as the burial	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnanc	y	_				23	3d. Date of deli	very
	death ie atter ad for u	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant a]Ectopic pregna] Other (specify)					Month	Day Year
2	that the death ed by the atte detached for	hys	9 🗆 Unknown	9□ Unknown									
•		ьу Р	Part II. Other significant conditions	contributing to death	but not resulti	ng in the u	nderlying cause	given in Pa	rt I.				the cause of death?
5	w requires been sign should be	ed								10	Yes 2□	No 3 ☐ Pro	obably 4X\(\sum_Unknow
3	> 0 10	piet								24a. Was	DSV	24b. Were au	topsy findings availab completion of cause of
	The ate has page	mo.								perfo 1 ☐ Yes	rmed? 2X No	death? 1 ☐ Yes	2 X] No
	cien: ertific ector,	Be (25. Was case referred to medical examiner?						ace of Deat	h (Check only o	one)		
	Physicien: this certific ral director,	ို	1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpat		VOutpatier	I 3 DOA		Nursing Ho	ome 5 Resi			eify)
	ife ing	iuo!	27. Manner of Death 1 ØNatural 5 ☐ Pending	28a. Date of Inj (Month, Da	ay Year)	Bb. Time o Injury	V	Vork?	□No	28d. Describe	how injury	occurred	
TO SIGN	Attending r death. sctor: After by the fune	icati	2 Accident investigatio		ium. At hom	o form at		□Yes 2	□No	28f Location /	Stmot and	Number or Du	ral Route Number,
	To the Hospitel or Attendi -within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	4 Homicide determined	28e. Place of In building, e	tc. (Specify)	o, iaini, Sti	eet, ractory, offic	UH .		City or To	wn, State)	umber of Au	a rioute (vuitibet,
1	spitel ours a		29a. Certifier 1 X Certifying PI	nysician: To the besi	t of my knowle	edge, deat	occurred at the	time date	and place	and due to the	cause(s) a	nd manner as	stated.
	24 h	edicai	(Check only 2 Medical Examone)	miner: On the basis and manner s	of examination	n and/or in	vestigation, in m	y opinion, o	leath occur	red at the time,	date and p	place, and due	to the cause(s)
	Nithin To the	Me	29b. Signature and title of certifier	11		2006	29c. Lice	ense numbe	er .		29d. Date	signed (Month	. Day, Year)
			M. H. O.	2 QVI	7 2 1 6	(1(1)	240	8262			MARCH		

State

Registrar

32. Registrar's Signature

#330, Rockville, MD 20852

parks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. A. Mendhiratta, 2401 Research Bl.,

31. Date filed (Month, Day, Year) MAR 31 2004

			For 1_ State	State of Mai	ryland / De		t of H	ealth a	and M	•	ygier	ne				
			Registrar 1. Decedent's Name (First, Middle, Las	1)		eruncau	e or t	Jeani		2. Date of [10.201	14	3 Tid98	2 G 4	†
	Physicia	an		u)						Month March		2004	⁄ear	3:00	то М	
	/Medic	al	Lois Ruth Grealis 4a. Facility Name (If not institution, give	atroat and number)		Ab Cibe	Town or	Location of		March		4c. County of	Death	3:00	Γ.	_
	Examin	er	Potomac Valley Nu			,	kvil])i Dealli			Montgo		17		
_			5. Social Security Number 6. Se		(In yrs. last birthe			If Under	24 Hrs.	8. Date of E					or Foreian	7
	Funeral Director				80 Yr	Months	Days	Hours	Min.	8. Date of E (Month) April	Day, Yea \mathbf{I}	1923	бh	¥8	or Foreign	
			Usual Residence of Decedent													_
	nylan how		10a. State 10b. County		10c. City, Town o									10d. Inside	City Limits	
	Se-1 s	Director	Maryland Montgome	ry	Rockvil										35 Z [] NO	_
	or 24	Dire	10e. Street and Number			10f. Zip						Citizen of Wh		-		
	ath w	- a	1235 Potomac Valle			208			:.0./0			ted St				_
	er de Items	au au	11. Marital Status	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 🕅 No	ver in U.S.	13. Was Dece If Yes, spe	dent of Hi city Cuba	ispanic Ori in, Mexicar	gin? (Spi 1, Puerto	Rican, etc.)	NO-		White,	can Indian, etc.		
36	rs aft	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	If Yes, Give Year or Dates:	'	1 🗆 Yes	2 X) No	Specify:				Specify:	Whit	e		
Ö	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "neturel", or Items 23a or 28e-f show aumatic avent, tha Madical Evant art must be notified at	per	15. Decedent's Ed	ucation	16a. D	ecedent's Usu	al Occupa	ation			16b.	Kind of Bus				1
215	hin 7.	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+	· · · · · · · · · · · · · · · · · · ·	Give kind of wo ife. DO NOT u	se retired	during mos ()	t or work	ng						
21	giene giene gritha	NO.	12		Lib	rarian						nsulti				_
pu	al Hy I oth	Be (17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Mida	lle, Maid	en Sumame,)			
Val	Ment Ment arked	္	Matthew Jones					Grac								_
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylar I Health and Mental Hygiene 1 Health and Mental Hygiene 1 Health and Mental Hygiene 2 how items 23a or 28e-1 show item 27 is marked other than "neture!", or Items 23a or 28e-1 show other traumatic avent. The Wedled Evert arriting the notified at		19a. Informant's Name/Relationship (7			Mailing Address								Code)		
	and lealth m 27 her t		William J. Greali 20a Method of Disposition	s/Son	1001 01 10	O Brill			Lncir	nati,		O 4524 Location - C		nun State		_
Baltimore,	ges in the first of the corot		1 ☐ Burial 2 X Cremation 3 ☐	Removal from State	Montgon	crematory or d	other plac	(e)	ApriÌ	-						
Ë	rtmer rtant rtant		* 4 □ Donation 5 □ Other (Specification 21. Signature) of Funeral Septice Limit		Crema	LOT LUIII.	THE		200 Pobe		Be	thesda	Fur	aryla oral	nd Home/	r
Bal	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		+ KACUA.	MO1		22. Name ar Rockvi Rockvi	lle, lle,	Inc. Mary	300 1and	West 20850	Mon -28	tgomer 05	y A	venue	Home	ä
			23a. Part1. Enter the disease, or company shock, or heart failure. List only	olications that caused to one cause on each line	he death. Do no	t enter the mod	de of dyin	g, such as	cardiac o	or respiratory	arrest,			Approxim Interval B Onset an	etween	
	Physician	8 4	Immediate Cause (Final disease or condition	a. Pneumoni	.a									5 Day		
	/Medical Examiner		resulting in death)	·	consequence of											
	LAGIIIIIO	<u>.</u>	Sequentially list conditions,	b. Parkinso	n's Dise								- 1-	.0 Yea	ars	_
8	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events	240 10 (07 110 1		•										
	axecu n and al-tra	xar	that initiated events resulting in death) Last	c. Due to (or as a	consequence of	:							-			
760,	e be e siciar e buri	cai		d												
99	eath certificate be executed attending physician and for use as the burial-transit															
Вох	h cert andin use	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		3 □Ectopic p	recoancy					23d. Date		-	V	
	deat	sicie	in the past 12 months?	4☐Pregnant at ti 9☐Unknown		5 Other (sp					. //	Mont	n	Day	Year	
P.O.	that the de led by the a detached t	Phy	9 Unknown Part II. Other significant conditions c			b d - b !		an in Danit		22a Die	d tabasa	l o use contrib	uto to t	ha causa o	death?	-
	Se Deq	Completed by Physician/Medl		ontributing to death but	, not resulting in t	ne undenying t	ause givi	en in Failt	•					ably 4		
0.0	w require been si should	eted	Dementia													
Records,	elaw hast	du	Osteoporosis							24a. Wi	as an topsy rformed:	pri	or to co ath?	mpletion of	s available cause of	
										1 ☐ Yes	2 X			2□ No		
Vit	Physicien: The k r this certificate ha ral director, page 2) Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatien	t 2 🗆 ER/Outp	atient 3 D	Oth	00		n <i>(Check onl</i> me 5 ☐ Re		€ □Othor	(Specie			
of	Phys ar this aral di	7: 70	27. Manner of Death	28a. Date of Injury	28b. Tir	ne of 2	28c. Injun	y at		28d. Describ				y /		
ion	Attending it death.	ig ig	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Inj	M M	Worl	Yes 2	No							
Division of Vital	Atte er deg recto by th	tific	3 Suicide 6 Could not be determined	28e. Place of Injur	y - At home, farn (Specify)	n, street, factor	y, office			28f. Location City or 7			or Rura	al Route Nu	ımber,	
Ö	tel or rs afte el Di	Certification:	hand	Vi -												
	To the Hospitel or Attending Phywithin 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral.	Medical	(Check only 2 Medical Exam	ysician: To the best of niner: On the basis of	examination and/										o(s)	
	the the the	Med	one) 29b. Signature and title of certifier	and manner state	90.	29	c. Licens	e number	<i></i>		29d. [Date signed	Month,	Day, Year)		_
	¥ ¥ ¥ 8			-/ht	111	g A	0060	758				ch 30				
	5		30. Name and address of person who	completed cause of de	ath (Item 23a) (T											_
			Valerie Kleshchelsvou	/ /			e, Si	lver S	prine	, Mary	1ano	1 2090	2			
		ate	31. Date filed (Month, Day, Year)	32. Registra	's Signature	, ,										
	Regist	rar	APR 0 2 20	04 Sener	par po	100	rekn	1								

			for State	State of Marylar	id / Dep	artment of H	lealth and N	lental Hygi	ene	10000
			Registrar		Ce	rtificate of	Death		g. No. 2004	12265
1. 26.	Physici	20	Decedent's Name (First, Middle, Last,)				Date of Death Month	Day Year	3. Time of Death
inter	/Medic		George Grund	ly				March 29		5:40P M
X	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of Death	
			Stella Maris			Towson		,	Baltimore	
*\ 	Funeral		5. Social Security Number 6. Sec.	DM 2005		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthp	place (State or Foreign ntry)
v Lo	Director		N/A		39 Yrs.			Dec. 18	, 1914 Engl	Land
	pus *		Usual Residence of Decedent 10a, State 10b, County	10c. Cit	ty, Town or Le	ocation			-	10d. Inside City Limits
	sho	'n								1 ☐ Yes 2 🔀 No
	88-1-18-1	Director	Maryland Montgome 10e. Street and Number	ery No	rth Po			10	g. Citizen of What Cour	-1-2
	with t					10f. Zip Code				
	s 23	by Funeral	13609 Query Mill R	Coad 12. Was Decedent Ever in U	C 12	20878	lianania Origina /Sa		Jnited King	
	er de Item	un	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	.3.	If Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, White,	
36	rs aft	y F	3 X Widowed 4 □ Divorced	1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:		Specify: Whi	ito
Ş	hou	edl	15. Decedent's Edu		16a. Dece	dent's Usual Occup	ation	1	6b. Kind of Business/In	
5	in 72	olet	(Specify only highest grad	le completed)	(Give	kind of work done DO NOT use retire	during most of work	ring		,
12	tied within 72 hours atter death with the Maryland Hygiene. sther than "natural", or Items 23e or 28e-f show ant, the Medical Exame act must be incitiled at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Insur	ance Age	nt		Insurance	
Maryland 21215-0036	Hyg Hyg She		17. Father's Name (First, Middle, Last)					e (First, Middle, M	aiden Sumame)	
au	d be ental ked c	To Be	Thomas Grundy				Elizabe	th O'Brie	en	
7	shou mar mat	-	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Maili	ng Address (Street			City or Town, State, Zip	Code)
S	id 2 ith a 27 is		Patricia Mary Davi	es/Daughter	1360	9 Ouerv 1	Mill Road	. N. Poto	omac, Maryl	and 20878
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: It item 27 is marked other than "natural", or items 23a or 28a-1 show may njury or other traumatic evant, the Medical Examination at the confiled at Once.	-	20a. Method of Disposition	20h I	Place of Dien	seition (Nama of			Oc. Location - City or To	
0	t: If i		1 ☐ Burial 2 🕅 Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	Removal from State Moi	îtgome	matory or other place	2004		athania Ma	11
Baltimore,	artme prtan injur		21. Signature of coneral Service License		emator.	ium, Inc. 2. Name and Addre		ert A. P	ethesda, Ma umphrev Fui	neral Home/
Ba	permil Depar Impor any ir once.		130.061	S LLL. M008	R R	ockville,	Inc. 300	West Mo	nt omery A	neral Home/ venue
	March Mar		23a. Part1. Enter the disease, or comp				Maryland			Approximate
760,	Physician /Medical Examiner, approximately provided the price of the p	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Ents. Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. LUNG CANCER Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect	quence of):					
O. Box 68	death certifica e attending ph d for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1	al death 3[⊒Ectopic pregnanc	1		23d. Date of delive	ery Day Year
ds, P.	The law requires that the ste has been signed by the bage 2 should be detache		Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	ınderlying cause gıv	en in Part I.		acco use contribute to the	he cause of death?
Vital Records,	w require been si should	Completed						24 116	1011111	<i>r r r r r r r r r r</i>
ĕ ĕ	e law has le 2 s	ldu						24a. Was an autopsy perform	prior to co	psy findings available mpletion of cause of
<u></u>		S						1 ☐ Yes 2	XNo 1 ☐ Yes	2 No
ij	hysician: The law his certificate has t I director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		011		h (Check only one		
5	hysithis of all dir	은	TI THE ZIMINO	i _ inpatient 2 _	ER/Outpatie		4 Nursing no		ce 6 X Other (Specif	HOSPICE
Ĕ	ing F	lo iii	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe how	v injury occurred	
sic	Attending Physician: r death. ector: After this certific. by the funeral director.	cat	2 Accident investigation 3 Suicide 6 Could not be	00 51 (15)			Yes 2 □ No	004 Landing (Ct)		10
Division of	l or At after o Direc' I in by	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, tarm, st fy)	reet, factory, office		City or Town,	eet and Number or Rura State)	il Houle Number,
	urs a		77.0				1			
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical		vsicien: To the best of my kno iner: On the basis of examina and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Month,	Day, Year)
)						DL	13721		3/301	104
	10		30. Name and address of person who c	ompleted cause of death (Ite	m 23a) (Type	Print)	. , 4		0/-/	
				OD 2300 DULAN			TIMONIUM,	MD 2109	3	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature					
	Regist		APR 0 2 20	104 Deniva	19	Spark	21			

5:40 p.m.

MARCH 29, 2004

GEORGE GRUNDY

			1 - For State Registrar	State of M	Marylan		artment tificate			ind Me		giene Reg. No.	20	04	12	266
£	Physici	an.	1. Decedent's Name (First, Middle, I	.ast)							2. Date of Dea Month	ith Day	,	Year .	3. Time o	
	/Medic		ETHEL IRENE		GURTZ						March	26	20	04	5:	40A ^M
	Examin	er	4a. Facility Name (If not institution, g				4b. City, T		ocation of				County of			
(44)	Fundad		Washington Adve		PILAI Age (In yrs. I	ast birthday)	If Under 1	Year	If Under 2		8. Date of Birtl	h	lontg			or Foreign
	Funeral Director	vi I	207-07-8800	1 □ M 2KDNF	85	Yrs.	Months	Days	Hours	Min.	Month, Day	(Year)	18	Penn	sylva	ania
	D	2.	Usual Residence of Decedent 10a. State 10b. County		100 Cit	, Town or Lo										
	shov	J.					Cation							10	d. Inside (1 🔀 Ye:	s 2 No
	28e-f	Directo	Maryland Prince 10e. Street and Number	George's	Ac	lelphi	10f. Zip (Code				10a. Citi:	zen of Wh	nat Count	v?	
	3a or	Ö	1928 Red Oak Dri	ive				783				-	S.A.		, .	
	death ms 2	Funeral	11. Marital Status	12. Was Deceder		S. 13. \			panic Orig	in? (Spec	city Yes or No- lican, etc.)		4. Race			
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or liems 23a or 28e-f show that the Medical Examinat must be notified at	by	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced		No No		Tes, speci			, гиело г	ncan, etc.)		Specify:	White, e		
Ş	72 ho	Completed	15. Decedent's (Specify only highest of			16a. Deced	ient's Usual	Occupat	ion	of workin	0	16b. Kir	nd of Bus	ness/Indi	ıstry	
	d within giene. rr than "ure the Mex	npie	Elementary/Secondary (0-12)	College (1-4c	or 5+)		kind of work DO NOT use						eral			
7	fled w flygier her ti		17. Father's Name (First, Middle, La	1 Year	r	Admi	nistr				(First, Middle,		ernm			
Maryland	0 = 0 \$	To Be	Austin Wallace								Klinge:		Sumame,			
a _Z	should and Men is marke		19a. Informant's Name/Relationship								Route Numbe					5704
	ss 1 and 2 should by Health and Ments iftam 27 is marked to other traumatic e		Dennis M. Gurtz	:/Son	20b. P	are of Disno	sition (Name	e of	-		Gaithe		rg,			20879
Baitimore,	Pages nent of ent: If it		1 ⊠ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of the Contro		te Park	ametery, cren Lawn I	natory or oth Memori Garder	er place) Lal 15)	03/29	9/				ary1	and
Balt	permit. Pages Department of I Importent: If its any injury or of		21. Signature of Funeral Service Lic	eezne		HI	Name and	Address INALI	of Facility	NERA	L HOME, Avenue,	INC	3.			20904
			23a. Part1. Enter the disease, or co shock, or beart failure. List on	implications that causely one cause on each	sed the death								rver_	í	Approxima nterval Be	ite itween
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Lung C											Onset and	Death
	/Medical Examiner			Due to (or	as a consequ	ience of):										
\$	pe jis	lner	Sequentially list conditions, if any, leading to immediate cause. Linter Uniterlying Cause (Disease or injury	b. — Due to (or	as a consequ	ience of):										
	be executed sician and burial-transif	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequ	ence of);								-		
/60,	ate be ex nysician he burial	cai E		d												
9	ng ph		IF FEMALE:													
ROX	eath certific aftending p	lan/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon 1☐Live birth	2 🗌 Fetal	death 3	Ectopic pre					2	3d. Date Month			Year
	at the death certificate by the attending phys tached for use as the	Physician/Med	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant 9□ Unknown		eath 5∟	Other (spe	c <i>rfy)</i>							,	
1		by Ph	Part II. Other significant conditions	contributing to death	but not resu	ılting in the ur	nderlying ca	use given	n in Part I.		23e. Did to	bacco u	e contrib	ute to the	cause of	death?
ğ	w requires that been signed to should be deta	edt	Hypertension								1 🗆 Y	es 2] No 3	Probal	oly 4 🗆	Unknown
ecords,	law re las be	Completed									24a. Was a	SV	24b. We	ere autops	y findings pletion of	available cause of
r =	: The lav	Con									perform 1 Yes		dea	ath?]Yes 2	□ No	
Vital	Physicien: Trthis certificateral director, ps	Be	25. Was case referred to medical examiner?	Hospital:							(Check only or			-		
ō	Phys rthis raldi	ד: דס	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date of li		ER/Outpatien 28b. Time of		c. Injury a	4 □ Nurs at		e 5 🗆 Reside					_
0	Attanding I ir death. actor: After by the funer	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigat		Day Year)	Injury	М		s 2□N	10						
DIVISION	≥ # # C	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	ad 286. Place of	Injury - At ho etc. (Specify	me, farm, str	eet, factory,	office	2/7/1	21	Bf. Location (Si City or Town	treet and n, State)	Number	or Rural i	Route Nur	nber,
	Hospita 4 hours Funara tely fille	Medical C	29a. Certifier 1⊠ Certifying (Check only one)	Physician: To the beseminer: On the basis	of examinat	wledge, death	occurred a	t the time	, date and nion, death	d place, ar	nd due to the c d at the time, d	ause(s) ate and	and mann	er as stat	ed. he cause(s)
	To tha within 2 To tha comple	Mec	29b. Signalure and little of certifier	and manner	sidleu.		29c.	License	number		2	9d. Date	signed (Month, Di	y, Year)	
			I would	& sea	MA		D-	-0053	3337			Marc	h 30	, 20	04	
	20		30. Name and address of person who Dorothy M. Sea	o completed cause of	of death (Item	23a) (Type, Lockwo	Print)	Su ive,	iite Silv	#205 er S	pring,	Mary	1and	209	01	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 0 2	32. Regi	strar's Signat		Spa						-			
	ricgioti	ui	1111111 0 0 1			/	//	-								

			1 - For State Registrar		laryland / De C	partment of F ertificate of	lealth and Death	Mental Hy	rgiene 2 Reg. No.	304	. 12	226
	Physici /Medi		Decedent's Name (First, Middle, Las HELEN	CECILI		GASPER		2. Date of De Month	7, 2004	Year	3. Time (
ge li	Examir	ner	4a. Facility Name (If not institution, give 16505 ARABIAN COL		")		SVILLE	h	4c. County			
	Funeral Director		5. Social Security Number 6. Security Number 171-01-1270 Usual Residence of Decedent	2X	ge (In yrs. last birthda 91 Yrs.	Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da Oct. 2	7, 1912	Cour	olace (State ntry) Sylva	
	Maryland If ahow	tor	10a. State 10b. County Maryland Charles		10c. City, Town or	Location esville	-			1	10d. Inside (City Limits
	with the	i Director	10e. Street and Number 16505 Arabian Cou	ınt		10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?	
036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-1 ahow ther, tha Medical Examerer must be tootified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 € If Yes, Give Year or Dates	No	3. Was Decedent of Hilf Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	USA 14. Rac Blac Specify	e - Americ ck, White,	can Indian, etc. ite	
21212-0036	ed within 72 ho giene. er than "natur f, the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or	5+) (Gi	cedent's Usual Occupi we kind of work done o . DO NOT use retired OMEMAKET	ation during most of wor))	king	16b. Kind of Bu	own F		
yland	a la b ≥	To Be	17. Father's Name (First, Middle, Last) John Velky				Anna Ho	nis	Maiden Surnam			
e, mar	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (7) Joseph J. Gasper 20a. Method of Disposition	ype, Print) - Son	1650	iling Address (Street a	Court, H		lle, MD	20637	7	
baitimor	t. Page rtment o rtant: If njury or		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licens)	Resurre	position (Name of ematory or other place ction Ceme	tery 4-1		Clinton		wn, State	
n	Dermi Depa Impo		23a. Part1. Enter the disease, or comp	obrain		22. Name and Addres Huntt Fune D. O. Box	ral Home 156. Wal	dorf, MD	20604			
	Physician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a ARTERI	ine.	enic ca				SE 4	Approxima Interval Ber Onset and	tween
,00,0	cate be executed physician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	s a consequence of):							
O. BOX 90	o the Hospitel or Attending Physician: The law requires that the death certification 124 hours after death. Or the Funeata Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date Mon	of deliver	,	Year
COLOS, P	quires that on signed t uld be deta	ρ	Part II. Other significant conditions co	ntributing to death t	out not resulting in the	underlying cause give	n in Part I.	23e. Did to	obacco use contri		e cause of d	
מום ומ	To the Hospital or Attending Physician: The law re within 24 hours after death. To the Funcial bisector: After this certificate has bee completely filled in by the funeral director, page 2 sho	Completed						24a. Was a autop perfor	sy pr med? de	/ere autop: rior to com eath? Yes 2	esy findings apletion of c	available ause of
	hysicia this certi al directo	To Be	1 193 2 140	Hospital: 1 Inpati			4 Italishing I k	20.00 m appendix	ne) ence 6 □Othe	r (Specify))	
	tending Fleath. tor: After the funer	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Inju (Month, Da	y Year) Injury	Work' M 1 □ Y	at ? es 2 □ No		ow injury occurre			
2	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicide determined	building, e	jury - At home, farm, s ic. <i>(Specify)</i>			City or Tow				ber,
	the Hosp hin 24 ho the Fune npletely f	Medical	one)	sician: To the best ner: On the basis of and manner st	of my knowledge, dea f examination and/or i ated.	nvestigation, in my opi	nion, death occur	red at the time, d	late and place, ar	nd due to t	the cause(s)
	To vit		29b. Signature and title of certifier		M	29c. License	3454		PRIL 8,			
n	P 6		30. Name and dress of person who compHILIP WISOTSKY, I	MD, 12070	OLD LINE		7, WALDO				111	
	Star Registra	_	31. Date filed (Month, Day, Year) APR 0 9	32. Re G istr	ar's Signature	docides						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2004 12261 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LEE GRIFFITH March 16, 2004 12:20 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death REEDERS MEMORIAL HOME BOONSBORO WASHINGTON 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 X M 2 □ F 220-74-5363 Yrs 58 28, 1945 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1XYes 2 No MARYLAND WASHINGTON BOONSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 141 SOUTH MAIN STREET 21713 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 HANDICAPPED HANDICAPPED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GEORGE WILLIAM GRIFFITH GENEVA LEE LAFOLETTE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUNE C. WYAND/SISTER 15 BEDROCK LANE, KEEDYSVILLE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 3 Removal from State 1 X Burial 2 ☐ Cremation 4 □Dentation 5 □Other (Specify) MOUNTAIN VIEW CEM. 3/19/2004 SHARPSBURG, MARYLAND 21. Signature of Funeral Se ce Licensee 22. Name and Address of Facility 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 23a. Pert 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) orobable willers Que to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 DEctopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 1 ☐ Yes 2 ☐ No 20 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Płace of İnjury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \)

/Medical Examiner The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

Baltimore, Maryland 21215-0036

nding physician and use as the burial-transit ned by the a detached f should I After thi death. the Director filled in by

Physician

/Medical

Examiner

Directo

by Funeral

Completed

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Examiner

Physician/Medical

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Certification: To

Medical

29a. Certifier

Funeral

Director

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al Hygiene.

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item 27 i

Department of P Important: If ite any injury or ot once.

Physician

To the Hospital of within 24 hours at To the Funeral C completely filled

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Robert Guedenet 21 Wyand Drive, Keedysville, Maryland 21756 / 301-432-2222

31. Date filed (Month, Day) 9 2004

29b. Signature and title of certifier

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DJ25/8

29d. Date signed (Month, Day, Year)

16/09

Registrar

			1 - For Stata Registrar	State of Maryland / Depa	artment of Health and rtificate of Death	Mental Hygie		1226
	Physic	an	Decedent's Name (First, Middle, Last BONNIE SMITH I			2. Date of Death	Day Year	3. Time of Death
	/Medi						, 2004	0330 A M
-	Exami	ier	4a. Facility Name (If not institution, give	· · · · · · · · · · · · · · · · · · ·	4b. City, Town, or Location of Dea		4c. County of Death	
			2333 Old Snow 5. Social Security Number 6. Se		Pocomoke City		Worceste:	
	Funeral Director			M 201 F 55 Yrs.	Months Days Hours Min		ear) Cour	place (State or Foreign oftry) yland
	death with the Maryland ms 23e or 28e-f show [TTUS] be notified at	ō	10a. State 10b. County MD Worceste	er Pocomoke			1	0d. Inside City Limits 1 ☐ Yes 2 No
	28e-	rect	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cour	
	h with	<u>e</u>	2333 Old Snow	Hill Road	21851	1	JSA	,
5-0036	or ite	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? I	Was Decedent of Hispanic Origin? (; 1 Yes, specify Cuban, Mexican, Puer I Ves 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify:Whit	etc.
5-0	72 hours natural', clical Ex	Completed	15. Decedent's Edu (Specify only highest grad	cation 16a. Deced	lent's Usual Occupation kind of work done during most of wo	nkina 16b	. Kind of Business/Ind	dustry
2121	S - 38	Id II	Elementary/Secondary (0-12)	College (1-4or 5+)	kind of work done during most of wo DO NOT use retired)		_	
	illed v Hygie ther t	ပို	12 17. Father's Name (First, Middle, Last)	Beaut	ician	P∈ me (First, Middle, Maid	ersonal (Care
an	should be filed within nd Mental Hygiene. marked other than ametic event, the M	80	Horace Smith		Miriam	•	ien Sumame)	
Maryland	s 1 and 2 should be filed withi f Health and Mental Hygiene. Item 27 is marked other thar other traumatic event, Tru M	ဥ	19a. Informant's Name/Relationship (Ty	rpe, Print) 19b. Mailin	g Address (Street and Number or R		v or Town, State, Zip	Code)
	alth ar 27 is er trau		Earl Hart/ Hush		Old Snow Hill			
Baltimore,	permit. Pages 1 and i Department of Health Important: If Item 27 any injury or other tr ance.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	natory or other place)		Location - City or To	
Ħ	permit. Page Department o Important: If any injury or once.		21. Signature of Fungful Service Licens		Name and Address of Facility HO	8/2004 Pc	comoke,	МО
ñ	Depa Impo any ii		Mul O D	Down Ho	ome, P.A. Poco	TIOWAY ME	elson Fun 21851	leral
	eath certificate be executed Example of the purial-transit E	dical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Lung Canc	en		Interval Between Onset and Death
39 X	e as t	w	IF FEMALE:					
P.O. Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a:	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		23d. Date of deliver Month	ry Day Year
rds, P	quires that the de n signed by the a uld be detached f	þ	Part II. Other significant conditions cor	tributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacc	o use contribute to the	
Il Records,	di ng Phyaician: The law requir n. After this certificate has been si funeral director, page 2 should	Completed				24a. Was an autopsy performed?	prior to com death?	sy findings available apletion of cause of
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	a a mital		ath Check on one)		
of	Phyaician: this certificanal director, I	ဥ	1 ☐ Yes 2 No	ospital:		lome 5 X Residence)
	ding l	lou	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Division	after deatl Director: In by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)		28f. Location (Street a City or Town, Sta	and Number or Rural ite)	Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (29a. Certifier (Check only one) 1 Certifying Phys	cician: To the best of my knowledge, death ter: On the basis of examination and/or investand manner stated.	occurred at the time, date and place estigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as sta nd place, and due to t	ited. the cause(s)
	To ti withi To ti	Ž	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, D	ay, Year)
			/ aul K Hry		024872	13	15/04	
), [H. 6	-		mpleted cause of death (Item 23a) (Type, P		sco mo Ke	City N	10
	Sta Registr	re.	31. Date filed (Month, Day, Year)	32. Begistrar's Signature				

X ⁽⁴⁾		1 - State Registrar 1. Decedent's Name (First, Middle, La		Certificate of	Death	2. Date of Deat	h	3. Time of Death
Physici /Medio	cal	JACKIE G 4a. Facility Name (If not institution, give	HAWKINS		or Location of Deat	APRIL 3	Day Year 2004	10:55 PM
Examir	ıer	16054 ENGLISH OA		BOWIE	or cocation or beat		PRINCE G	
uneral rector		5. Social Security Number 6. S 4/1-68-7054					9. Birt	thplace (State or Foreigountry)
show	5	Usual Residence of Decedent 10a. State 10b. County	,	Town or Location				10d. Inside City Limits
or 28a-f	Director	MD PRINCE 10e. Street and Number		10f. Zip Code	1.6	1	0g. Citizen of What Co	ountry?
Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event. It a Middical Examinar must be inclifted at once.	by Funeral	16054 ENGLISH 11. Marital Status 1 □ Never Married 2 ☼ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	207 3. Was Decedent of If Yes, specify Cul 1 □ Yes 2 🛣 No	Hispanic Origin? (S pan, Mexican, Puer	Specify Yes or No- to Rican, etc.)	USA 14. Race - Ame Black, Whit Specify: B	e, etc.
an "natura Madical E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of wo	rking	16b. Kind of Business DEPARTMENT	
is marked other than " aumatic event, tre Mis	Be	17. Father's Name (First, Middle, Last	4	COMPLIANCE		me (First, Middle, M		<u>E</u>
7 is marke traumatic	은	RUFUS HAWKINS Wallow Elizabeth Ha MICKY HAWKINS / WI		19b. Mailing Address (Stree 16054 ENGLI	and Number or Ri		City or Town, State, 2	Zip Code)
t: ff itam 2 y or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Control	20b. Pla ce Removal from State	ace of Disposition (Name of metery, crematory or other pla NCLIFF CEMETE)	ace)	Date	20c. Location - City or SPRINGFIELI	Town, State
Importan any injury once.		21. Signature of Fundal Service Lice	(1)	22. Name and Addr	one of Equility	BERT E. I	EVANS FUNEI	
sician edical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	Do not enter the mode of dy	ing, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death
miner	iner	S. uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bbue to (or as a consequ					
ysician and e burial-transit	cai Examiner	Cause Disease of injury that initiated events resulting in death) Last	c. Due to (or as a consequent	ence of):				
by the attending physitached for use as the l	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopic pregnant	су		23d. Date of de Month	livery Day Year
been signed by the should be detached	b	Part II. Other significant conditions	contributing to death but not resu	lting in the underlying cause g	iven in Part I.	23e. Did tob	oacco use contribute to	the cause of death?
ate has page 2	Completed					24a. Was a autops perform	y prior to	utopsy findings available completion of cause of [2] No
this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:		thor	ath (Check only on		
After this funeral dii	tion; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigate	28a. Date of Injury (Month, Day Year)	28b. Time of Injury W	4 Nursing i	_	ence 6 Other (Spe ow injury occurred	cify)
within 24 hours are local. To the Funeral Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not determined		me, farm, street, factory, office)	9	28f. Location (St City or Town	reet and Number or Ri 1, State)	ural Route Number,
y fille	edical (hysician: To the best of my know miner: On the basis of examinati and manner stated.					
Pe Fu				29c. Licer	nse number	2	9d. Date signed (Mont	h. Dav. Year)
To the Funeral D	ž	29b. Signature and title of certifier	11 1 00	t- 1 20 1	7205		01.100	ha

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of M	laryland	,	artment rtificate					~ ^ ^	04	12271
	Physici	an	Decedent's Name (First, Middle, La.	st)						2.	Date of Dea Month	ith Day	Year	3. Time of Death
	/Medic	cal	Wyoneida Hogga: 4a. Facility Name (If not institution, give		·1		4h Cihi	Town or I	ocation o		pril	7 20 4c. County	004	5:30 P M
	Examin	er	Frederick Memor				4b. City,	ederi		or Death			deric	-
	Funeral		5. Social Security Number 6. S	ex 7. A	ge (In yrs. Ia:	st birthday)	If Under	1 Year	If Under		Date of Birth	1	9. Birthp	lace (State or Foreign
	Director		219-00-9083	□M 21821.F	59	Yrs.	Months	Days	Hours		(Month, Day rch 1(1945	Mar	yland
	and		Usual Residence of Decedent 10a, State 10b, County		10c. City.	Town or Lo	cation						1	Od. Inside City Limits
	Manyi f sho	ō	Maryland Frederic	ck	F	reder:	ick							1⊠Yes 2 ☐ No
	r 28a	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cour	ntry?
	23a o	alD	1603 Rosemont Ave	nue				217	02			Unit	ed St	ates
	tems erms	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	. 13.	Was Deced If Yes, spec	ent of His	panic Ori , Mexicar	gin? (Specify n, Puerto Rica	Yes or No- an, etc.)	14. Rad Bla	ce - Americ	
36	rs afte	by Fi	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 21X If Yes, Give Year or Dates:			1 ☐ Yes 2	No.	Specify:			Specif	y: Wh	ite
9	72 hours after death with the Maryland natural; or Items 23a or 28a-1 show dical Exactine roust be notified at	ted	15. Decedent's Ed	ducation		16a. Dece	dent's Usua	l Occupat	tion			16b. Kind of B	usiness/In	dustry
215	thin 7 e.	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT us	k done du e retired)	<i>iring m</i> os	t of working				
2	filed within Hygiene. other than "		5			Custo	dian		10 11 11	1.11 (5		Maint	-	e
Maryland 21215-0036	12 should be filed within n and Mental Hygiene. 7 Is marked other than "traumatic event, the Max	Be	17. Father's Name (First, Middle, Last) Clyde Hoggatt							e F. D		Maiden Surnar	πe)	
2	should hd Me mark matic	2	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address					r, City or Town,	State, Zip	Code)
	1 and 2 : Health ar em 27 Is		Kenneth R. Miller	/ Brothe	r	11105	Putm	an R	d.;	Thurmo	nt, MI	21788		
Baltimore,	S = = 0		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	20b. Pla	nce of Dispo	sition (Nam natory or ot	ne of ther place,) !	Date April	Q	20c. Location	City or To	wn, State
Ĕ	Pages ment of I tent: If its jury or o		* 4 □ Donation 5 □ Other (Specif	70		haven			У	20	04	Freder	ick,	Maryland
Ball	permit. Page Department of Importent: If any injury or once.		21. Signature of Freral Service Up 1			Re 9.	Name and Sthav 501 Ca	d Address Zen F atoct	of Facilit uner in M	al Ser tn. Hw	vices y. Fr	, Skkot ederick	Cody	7 P.A. 21701
			shock, or heart failure. List only	plications that cause one cause on each	ed the death. line.	Do not ent	er the mode	e of dying,	, such as	cardiac or re	spiratory arr	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Preun										I Week
	/Medical Examiner		1 Southing in South	b. Ventri	s a conseque	1 1	-1 n	17		(+1	A.	+		+.1
	, 0	ler	Sequentially list conditions, if any, leading to immediate	Due to (or a	s a conseque	Sept ince of):	a) Vi	ejeca	07	the	ne	art_		ongenilal
	cuted od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	. Chro	nic	4>	VD DX	ia					i	D years
90	cate be executed oblysician and the burial-transit	I Ex	resulting in death) Last	Due to (or a	s a conseque	ince of).	/							,
8760,	The law requires that the death certificate be executed to the same signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical		d										
9 x	death certifica attending phate as the	/Me	IF FEMALE:	23c. If yes, outcom-	e of pregnanc	cy						23d Da	te of delive	in.
Вох	death a atten	Iclan	23b. Was decedent pregnant in the past 12 gronths? 1 □ Yes 2 M No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal d	leath 3□	Ectopic pre Other (spe						nth	Day Year
P.O.	that the do	hys	9 Unknown	9□ Unknown										
	res tha igned be del	by P	Part II. Dther significant conditions of	ontributing to death	but not result	ting in the u	nderlying ca	ause giver	n in Part I.		23e. Did tol	bacco use cont		e cause of death?
ord	v requir been si should	ted									1 □ Ye	es 2 No	3 Prob	ably 4 □Unknown
of Vital Records,	The law cate has b page 2 st	Completed									24a. Was a autops perform	SV	Were auto prior to cor death?	psy findings available inpletion of cause of
a	(0		05 W								1□ Yes 2	2XNo		2 No
Ξ	Physician: this certificantal director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ient 2∏ F	R/Outpatier	it 3□ DO.	Other		of Death (Ci		<i>ne)</i> ence 6 □Oth	or (Specifi	
1 0	ding Phy		27. Manner of Death	28a. Date of Inj	urv 2	28b. Time of	-	Bc. injury a Work?				ow injury occur		7
ior	Attending r death. ector: After by the fune	atlo	1 Natural 5 Pending 2 Accident investigation	1	ay rear/	IIIJuly	М		es 2 🗆	No				
Division	l or Attendate death Director:	Certification;	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Ir building, e	njury - At hom atc. (Specify)	ne, farm, str	eet, factory,	, office		28f.	Location (St City or Town	treet and Numb n, State)	er or Rura	l Route Number,
	ospital or A hours after unerel Direc ly filled in by		29a. Certifier 11x Certifying Ph	ysician: To the bes	t of my knowl	ledge, death	occurred a	at the time	a, date an	d place and	due to the co	ause(s) and ma	anner se et	ated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	ledical	(Check only 2 Medical Exar	niner: On the basis and manners	of examinatio	on and/or in	vestigation,	in my opii	nion, dea	th occurred a	t the time, d	ate and place,	and due to	the cause(s)
	To To	Σ	29b. Signature and title of certifier	20123			29c.	License	L //	Mar	yland 2	9d. Date signe	a (Month, 1	vay, Year)
•	1 Ĺ.		30. Name and address of person who	completed cause of	death (Item 2	23a) (Type	Print)	TX	07	1		4	-0-	VT
	4		Stephen Lee M	D 610.	Solare	× ct	- , F,	rede	eric	KI	1ary	land	21	703
	Sta Registi		31. Date filed (Month, Day, Year) APR 0		trar's Signatu	re ∕	4	Spo	K	/		9d. Date signer 4 Jand		

			State of Maryland / Department of Health and N 1 - State Registrar Certificate of Death		giene 2 Reg. No.	004	12272
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic		Vaughn Benjamin Horner, Sr.	April	2	2004	15:58PM
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ANUSULA REPORT SALISBU	//	4c. Cou	inty of Death	1100
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day	h ,		ace (State or Foreign
	Director		213-16-7085 12M 2 F 83 Yrs. Months Days Hours Min.	10-04-		Mary	
	pu k		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				d. Inside City Limits
	Maryla f sho	ō				1.5	1 Yes 2 No
	s after death with the Maryla , or Items 23a or 28e-f short in illust is use to myllfied at	Director	MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code		10g. Citizen	of What Count	ry?
	th with	al D	104 Johnson Drive 21804		I	JSA	
	ems er r	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spr. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - America Black, White, e	
36	s afte	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify:			cify:	
Ş	2 hour		15. Decedent's Education WW.I.I. 16a, Decedent's Usual Occupation		16b. Kind o	Wh f Business/Indi	ite
215	thin 72 9. 9n "na	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+) (Give kind of work done during most of work life. DO NOT use retired)	ing			
21	be filed withintal Hygiene. Id other then	Соп	12 none Accountant			rva Pov	ver
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or Items 23a or 28e-f show eumatic event. It e Maryland Examiter or unit be multiled at	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name Contain File				
Σ	s 1 and 2 should f Health and Mer item 27 Is marke other treumatic	2	John Horner Sadie E1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura				Code)
S S	and 2 seath ar n 27 ls		Jerldean Horner/Wife 104 Johnson Drive, Sal		•		
ē.	s 1 and 2 of Health item 27 I		and the state of t	Date	20c. Location	on - City or Tov	m, State
<u>.E</u>	Page ment c ent: If ury or		Asbury U.M. Cemetery 04/0	6/2004	Mt. Ve	rnon, N	Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre	1	11. Signature of Funeral Service Licensee H22. Name and Address of Facility Home				
	20 = a d	1	MO0295 11673 Somerset Avenu	ıe, Prir	cess		ID 21853 Approximate
	5.	/	A3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line. Immediate Cause (Final	or respiratory an	rest,	1	Interval Between Onset and Death
	Physician /Medical	1	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	· · · · -		-	
. /	Examiner		Right atrial Cardiac	throm	645		
	70 #	iner	cause. Enter Underlying				
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events c				
.09	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		Due to (of as a consequence of).				
68760,	ficate I physi	edlcal	d				
Вох	leath certifica attending ph I for use as ti	n/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d.	Date of deliver	y
	ne deat the attor	hysiclan/Me	1 Tyes 2 No 4 Pregnant at time of death 5 Other (specify)			Month [Day Year
rnet Is, P.o	that the d ed by the detached	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23a Did to	hacca usa o	antributa ta the	cause of death?
ds,	ires tha signed d be del	d by	Part in Other significant conditions combuting to death but not resulting in the underlying cause given in Part i.	1	es 2 \square No		
3. Ab	w requii been s should	ompleted		24a. Was a	an 24	h Were auton	sy findings available
	The lav	omp		autop: perfor	sy med?	prior to com death? 1 \Boxedath Yes 2	pletion of cause of
h h Vital		Co	25. Was case referred to medical 26. Place of Death		2 No	TU Yes 2	: NO
400	S 10	To B	examiner? 1 Yes 2 No Hospital: 1 Ninpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	me 5 Resid	ence 6 🗆	Other (Specify)	
300	ng fte	on:	1 Natural 5 ☐ Pending (Month, Day Year) Injury Work?	28d. Describe h	ow injury oc	curred	
\sqrt{a} Division	or Attending Phatter death. Director: Atter the	ertification;	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 28e Place of Injury - At home farm street factory office.	28f. Location (S	treet and Nu	mher or Ruml	Route Number
Div	after after Direct	ertlf	4 Homicide determined determined determined determined determined building, etc. (Specify)	City or Tow	n, State)	mber of ribiar	rioute ivanibel,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical C	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the ded at the time, o	ause(s) and late and plac	manner as sta æ, and due to t	ted. he cause(s)
	To the within To the	Me	29b. Signature and title of certifier 29c. License number	5	-	ned (Month, D	
			Furt wendym, Surgeon 1746536		Apri	12,	2004
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lift WELTBERE, W 100 E CARUIT ST	11/56	1/19	no	
	Sta Registi		31. Date filed (Month, Day, Year) APR 0 8 2004 APR 0 8 2004	•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1.

		1	For State Registrar	State of Marylar		ent of Health and cate of Death	a Mentai Hy	giene ZUUL Reg. No.	12273
76 ·-	nysicia	in i	1. Decedent's Name (First, Middle, Last	FRANCE	=5 1	HARVEY	2. Date of De Month	Day Year	3. Time of Death 02/8 AM
) E	Medic xamin neral	er	Aa. Facility Name (If not institution, give PON) Region 5. Social Security Number 6. Se	street and number) Medical	Cester 4b.	City, Town, or Location of D SAUSSUM nder 1 Year If Under 24 Iths Days Hours N	Hrs. 8. Date of Bin	ay, Year) Co	nplace (State or Foreign untry)
P ,	ector		Usual Residence of Decedent 10a. State 10b. County WORCE	10c. Gi	y, Town or Location	10 K E	10-1	9-26 M	10d. Inside City Limits 1 ☐ Yes 2 No
th with the N	internatifi	Funeral Director	10e. Street and Number	Road		21851		10g. Citizen of What Co	untry?
1215-0036 within 72 hours after death with the Maryland ene.	Examinerm	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		ecedent of Hispanic Origin' specify Cuban, Mexican, Pi es 2 No Specify:	? (Specify Yes or No uerto Rican, etc.)	Specify: B	
d 21215-0036 filed within 72 hours aff Hygiene.	the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give kind of life, DO No	Usual Occupation of work done during most of out use retired) Poulty Lab	working OPOR	Poultry	Industry
Maryland 2 Id 2 should be filed Ith and Mental Hygic	natic event.	To Be C	17. Father's Name (First, Middle, Last) LORD Brith 19a, Informant's Name/Relationship (7)	ingham	7		UISE	Maiden Sumame)	in Code)
more, Ma Pages 1 and 2 s	in item 27 is marked utter their materiar, or remain 25a or 26a in or or other freumatic event. It a Medical Examinar must be mutified at		Phyllis Timmon s 20a. Method of Disposition 1×Burial 2 □ Cremation 3 □	/daughter 200.	2006 Place of Disposition cometery, crematory	CROPPER C (Name of or other place)	T. Pocen	20c. Location - City or	471 851 Town, State
Baltimore, permit. Pages 1 a Department of He	any injury or once.		*4 Donation 5 Other (Specify 21. Signature of Funeral Service Lident	St.	JAMES UM 22 Nam BE	MC Cem. Harden Address of Facility.	-10-04 FUNERAL reet t	HOCOMOI HOME	4. MU 21851
Phys	ician dical		23a. Part 1. Anter the disease, companies only of the shock, and failure. I st only of the shock is a state of the shock o	a	th. Do not enter the	mode of dying, such as car			Approximate Interval Between Onset and Death
Exan	niner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consec					
68760, ficate be executed	pnysician and the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consect	quence of):				
Box 6	igned by the attending ph be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3 Ector	pic pregnancy or (specify)		23d. Date of del Month	ivery Day Year
Records, P.O	should be deta	þ	Part II. Dther significant conditions of	ontributing to death but not res	sulting in the underly	ing cause given in Part I.	0	tobacco use contribute to Yes 2 No 3 Pr	the cause of death?
	page 2	Completed					1 Tes	ormed? death? 22No 1 Yes	topsy findings available completion of cause of 2 \(\) No
of Vita		o Be	25. Was case referred to medical examiner? 1 Yes 2 M	Hospital: 1 Inpatient 2] ER/Outpatient 3[Other	Death (Check only ig Home 5 Res	one) idence 6 Other (Spec	cify)
Attending Ph	Alter th funeral	ertification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		28b. Time of Injury M	28c. Injury at Work?	28d. Describe	how injury occurred	
DIVISHOSPITE OF AU	To the Funeral Director: completely filled in by the	O	4 Homicide determined	28e. Place of Injury - At he building, etc. (Special Special S	fy)		City or To	Street and Number or Ruwn, State)	
To the Hospitel within 24 hours a	le Fun letely	Medical		niner: On the basis of examinand manner stated.					
To th	Comp	Me	29b. Signature and title of certifier	/		29c. License number		29d. Date signed (Monti	
			> Zu Nah			Do51359		March 315t	2004
			30. Name and address of person who can be seen and address of person who can be seen as a seen and seen and seen address of person who can be seen as a seen		m 23a) (Type, Print) とろいべり				
	Sta		21 Date filed (Month Day Year)	32. Registrar's Sign	aturo				

228-24-0995

State of Maryland / Department of Health and Mental Hygiene

		Cate of Maryland, De	Certificate of Death	Reg.	2001	12271
П	Physician	1. Decedent's Name (First, Middle, Last) MILDRED FRANCES HYMILLER		2. Dete of Deeth Month MARCH 24,	Bax O4 Year	3. Time of Death 11:45 PM
and the	/Medical Examiner	4e Fecility Neme (If not institution, give street end number)	4b. City, Town, or		4c. County of Deeth	11:45 PM
	Examiner	WESTMINSTER NURSING/REHABILITATION	CENTER WESTMINS	TER	CARROLL	
	Funeral Director	5. Social Security Number 219-01-1719 6. Sex 1 Age (In yrs. lest birtho	Months Days Hours Min	8. Date of Birth Month Day Ye DECEMBER	9. Birthple 15,1919 MA	ace (State or Foreign KYLAND
	/land	10a. State 10b. County 10c. City, Town of	r Location		10	d. Inside City Limits
	e Man	MARYLAND CARROLL WESTMI	NSTER			1 X Yes 2 □ No
	th with the Ma 23a or 28a-f s at be notified	10e. Street end Number 235 STACY LEE DRIVE	10f. Zip Code 21158	_	Citizen of What Countries TTED STATE:	•
020	urs after death v ai', or items 23s Examiner mant by Funeral	11. Merital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 YS Widowed 4 Divorced 12. Was Decedent Ever in U, S. Armed Forces? 1 Yes 300 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puel 1 ☐ Yes 2 XX Specify:	Specify Yes or No- to Rican, etc.)	14. Race - America Black, White, e Specify: WHTT	tc.
Baltimore, Maryland 21215-0020	in 72 ho in matura fedeal	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occupation live kind of work done during most of wo le. DO NOT use retired) PRESSER	rking	OAT FACTOR	
/land	2 should be filed with and Mental Hygiene. is merked other than aumatic event, the M To Be Comm	17. Father's Neme (First, Middle, Last)		me (First, Middle, Maid INA MAGERS	,	
, Man	C = 0 -	19a. Informant's Name/Relationship (Type, Print) THOMAS J. HYMILLER/SON 23	ailing Address (Street and Number or R 5 STACY LEE DRIVE,		105	
imore	Pages nent of int: If It	1 DBurial 2 Cremation 3 Removal from State			. Location - City or Tow YKESVILLE ,	
Balt	permit. Pag Department Important: It any Injury o pnce.	21. Signature of Funeral Service Licensee	22. Name and Address of Facility MYERS-DURBORAW FU 91 WILLIS STREET,			157
1	ė	23a. Part1 Enter the disease, or complications that caused the death. Do not shock or heart failure. List only one cause on each line.			1	Approximate nterval Between
	Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)				Dinset and Death
	executed n end iel-transit Examiner	b. How to (or as a con			/	54ps
68760,	death certificate be executed eathending physician end ed for use as the buriel-transit siciary/Medical Examin	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events could be caused to the country of the cou			2	Sys
89 X	£ 5 5 5	resulting in death) Last	and	_		84yr
Box	death cer attendir d for use	Part II. Other significant conditions contributing to death but not resulting in the	O underlying course gives in Bart I	22h Did tohoo		he sawes of death?
s, P.O.	requires that the death ce een signed by the attendi hould be detached for use eted by Physician/I	ratio. Other significant conditions contributing to death out not resulting in the	e underlying cause given in Fart I.	1 ☐ Yes	2 2 Proba	
of Vital Records,	aw requi			24a. Was an au performed	? avail	e autopsy findings able prior to pletion of cause eath?
a B	cete has to page 2 s			1 Yas	2 XNO 10	Yes 2□ No
Z.	Physician: The this certificate ral director, page to I: To Be Co	25. Was case referred to medical examiner? 1 Yes 2 No	Other:	ath (Check only one)		
	After fune	1	e of 28c. Injury at	28d. Describe how in	6 □Other (Specify) njury occurred	
Division	tal or Attanding P s efter death. at Director: After t ed in by the funera Certification:	3 ☐ Suicide 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rural I ate)	Route Number,
	Hospit 24 hour Funer tely fill	29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of my knowledge, do 2 Medical Examiner: On the basis of examination end/or and manner steted.	eath occurred at the time, date and place r investigation, in my opinion, death occu	and due to the cause	e(s) and manner es stat and place, and due to the	ted. he cause(s)
D	^	30. Nervis and address of person who completed cause of death (Item 23e) (Type 31. Date filed (Month, Day, Year) 32. Register's Signature MAR 2 9 2004	29c. License number	29d. [Date signed (Month, De	ay, Year)
	MIT	30. Neme and address of person who completed cause of death (Item 23e) (Type	pe, Print)	1	,	/
	State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	toole Kond, M	les tominst	ter MD.	21157
	Registrar	MAR 2 9 2004 Segme #	Societies			
DH	MH 16 Rev 6/95		7			

			. For	State of Ma		d / Depa					ntal Hy	giene			
			1 - State Registrar			Cei	rtificate	e of L	Death			Reg. No	. 2004	122	75
	Physici	an	1. Decedent's Name (First, Middle, L	.ast)						2	. Date of De Month	ath Da	ıy Year	3. Time of De	
	/Medi		Sterling LeRoy H								arch 2		2004	2:15 A	M M
£"	Examir	ier	4a. Facility Name (If not institution, g						Location of	f Death			. County of Death		
	Funeral		7332 John Picket 5. Social Security Number 6.		je (In yrs. i	ast birthday)	If Under		If Under 2	24 Hrs. 8	. Date of Bir (Month, Da		arroll 9. Birth	place (State or Fo	reign
	Director		213-38-6796	1⊠M 2□F	82	Yrs.	Months	Days	Hours	Min.	ec. 25	1^{y} , 1^{y}	921 Mary	_{ntry)} ` Land	
	pu *		Usual Residence of Decedent 10a, State 10b, County		10c City	, Town or Lo	cation						2000	10d. Inside City L	imite
	sho	ŏ	Maryland Carroll			odbine								1 ☐ Yes 2 f	
	28a-	rect	10e. Street and Number		WO	оавтне	10f. Zip	Code				10g. Ci	tizen of What Cou	ntry?	
	h with	Funeral Director	7332 John Picket	t Rd.			2179	7				Unit	ted State	es	
	ems 2	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13. \	Was Deced	lent of His	spanic Orig	gin? (Specif	fy Yes or No		14. Race - Americ Black, White,	can Indian,	
ဓ္ထ	or Ite		1 Never Married 2 Married	1 ☐ Yes 2 🔯 I If Yes, Give			1 ☐ Yes 2		Specify:	,,	Jul., 0.0.,			ite	
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23a or 28a-f show ther the Medical Examinat mermust be redified at	Completed by	3 Widowed 4 Divorced 15. Decedent's	Year or Dates:		16a. Deced	lent's Heus	I Occupa	tion			16b K	(ind of Business/In		
5	n na	plet	(Specify only highest of	grade completed)	F.()	(Give	kind of wor DO NOT us	k done d	uring most	of working		100.1	Circ or Dusinessein	idustry	
212	d with giene	mo	Elementary/Secondary (0-12) 12th	College (1-4or 5	5+)	Farme	r					A	Agricultu	re	
덛	al Hy 1 othe vent,	BeC	17. Father's Name (First, Middle, La	st)					18. Mother	r's Name (/	First, Middle	, Maider	n Sumame)		
yla	Ment Ment arked	ည	LeRoy Harrison								eather				
Mar	12 sh hand 7 is m iraum		19a. Informant's Name/Relationship				•						or Town, State, Zip	o Code)	
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or flems 23a or 28a-f show any injury or other traumatic event, the Marifical Expresser must be rediffied at Angle.		Shirley Dubbert 20a. Method of Disposition	(Daughter)	20b. P	lace of Dispo	sition (Nan	ne of		d. Wo	odbin	20c. L	IT) 21797 ocation - City or To	own, State	
ğ	ages ont of t: ff it y or o		1 ⊠ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		C	emetery, cren	natory or of	ther place	.	0.100.1					
Baltimore,	artme ortan injur	1 3	21. Signature of Funeral Service Lice	•	MOL	22	. Name an	d Addres	s of Facility	/			dbine, M		
ä	Depa Impo any ir		MAN K	llow		B	urrie 212 W	r-Qu	een F	unera	1 Dir	ecto	rs, P.A. field, M	a 2170/	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused by one cause on each li	d the death	. Do not ent	er the mode	e of dying	, such as c	cardiac or r	espiratory a	rrest,	t tetti	Approximate Interval Betwee	n
	Physician	V	Immediate Cause (Final disease or condition			aner.	acti	_	Can	ncar				Onset and Dear	h
(/Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):								,	
	Examine	_	Sequentially list conditions,	b Due to (or as		unnes of							_		
	led Isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury)	Due to (or as	a consequ	derice or):									
	and and al-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as	а сопѕед	uence of):									
760,	icate be executed physician and s the burial-transit	call		d											
89	tificat ng phy as th		IE SENALE.												
Вох	th cer tendir or use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			Ectopic pre	egnancy					23d. Date of delive	ery Day Year	
П	the at	/slcl	1 Yes 2 No	4□Pregnant at 9□Unknown	t time of de	eath 5□	Other (sp	ecify)					Moran	Day 16a1	
<u>Ф</u> О	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	by Physician/Med	Part II. Other significant conditions	s contributing to death b	out not resu	ulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did t	obacco	use contribute to the	he cause of death	1?
Vital Records,	uires l signé		No	10			, ,	3			10	Yes 2	□No 3□Prob	ably 4 Unkr	own
Ö	w require been signature	Completed									24a. Was	an	24b. Were auto	psy findings avai	lable
Be	: The law cate has I	шо										rmed?	death?	mpletion of cause	of
ital	ician: Th certificate ector, pag	a	25. Was case referred to medical	1		· · · · · · · · · · · · · · · · · · ·			26. Place	of Death (C	1 ☐ Yes Check only o	2 No	1 1 165	2□ No	
>	Physician: r this certific ral director,	To B	examiner?	Hospital: 1 ☐ Inpatie	ent 2 🗆	ER/Outpatien	t 3 🗆 DO	A Othe	r: 4 □ Nur:	sing Home	5 Resi	dence	6 ☐Other (Specif	y)	
Division of	ding Phys th. After this funeral dir		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry y Year)	28b. Time of Injury	2	8c. Injury Work	at ?	280	d. Describe l	how inju	ry occurred		
sio	Attending r death. ector: After by the funer	catl	2 Accident investigat 3 Suicide 6 Could not	be			М		′es 2□N						
ĭŽ		ertification;	4 Homicide determine		ury - At ho c. (Specify	me, farm, str	eet, factory	, office		281	City or To		nd Number or Rura 9)	ii Houte Number,	
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	O	29a. Certifier 12 Certifying	Physician: To the best	of my kno	wledge, death	occurred a	at the tim	e, date and	place, and	d due to the	cause(s) and manner as s	tated.	
	e Hos 24 h e Fur	edical	(Check only 2 Medicel Ex	aminer: On the basis of and manner sta	f examinat	tion and/or inv	vestigation,	in my op	inion, death	h occurred	at the time,	date and	d place, and due to	the cause(s)	
	To the within 2/	Me	29b. Signature and title of certifier	1 ~				. License					ite signed (Month,		
	2)		Hound	hours.	m. D	· .	14	J-41	0155	11 2		3	126/0	4	
	660		30. Name and address of person wh	o completed cause of d	death (Item	23a) (Type,	Print)		0 L	1,	04.	.,	1 2 12-	1 911	- 7
	D	,	31. Date filed (Month, Day, Year)	ion tz m. 1 32. Regin 2 2004	ar's Sinn	55 S	Can	ter	ゾケ、	Wa	LJ / m.	450	reh, M.	a, /	
	Sta Regist		APR 0	2 2004	es o oigna	J.	Local	2							

			For Stete Registrar	State of Marylar	•	artment of Hertificate of E			2004	1227
	Physici		Decedent's Name (First, Middle, Last) Myrtle B	. Hardtke				Date of Death Month Da Lar. 29, 20	004 Year	3. Time of Death 4:50 A M
	/Medic Examin		4a. Facility Name (If not institution, give National Luth			4b. City, Town, or Roc	kville		County of Death	ery
	Funeral Director		5. Social Security Number 218-52-2082 6. September 1 C	7. Age (In yrs. 101	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	B. Date of Birth (Month, Day, Year) (an. 26, 19	9. Birthp Coun 903 Mary	place (State or Foreign http) y Land
	Maryland I-f show	tor	10a. State 10b. County	gomery 10c. Ci	ty, Town or Lo	Rockvi	lle		1	0d. Inside City Limits Yang 2 □ No
	th with the 23a or 28a ast be not	ai Director	10e. Street and Number 9701- Veirs	Drive		10f. Zip Code	20850	10g. Cit	tizen of What Coun USA	itry?
036	be filed within 72 hours after death with the Maryland that Hygiene, od other than "natural", or flems 23a or 28a-1 show svent, it e Medical Examiner must be mailted at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ▼No	panic Origin? (Spec , Mexican, Puerto Ri Specify:	ify Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
Maryland 21215-0036	i within 72 ho iene, r than "natur it e Modical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupat kind of work done di DO NOT use retired) emaker	ion uring most of working	7	ind of Business/Ind	dustry
land ?	should be filed and Mental Hygis marked other umatic svent, It	To Be C	17. Father's Name (First, Middle, Last) Edgar N. Culley	7				First, Middle, Maiden g Schmid	,	
	tra	•	19a. Informant's Name/Relationship (Ty Rev.Dr.Reichard	d- Executor	97	01- Veir	nd Number or Rural is Dr., F	Route Number, City o Rockville	or Town, State, Zip P, Md • 208	Code) 3 5 0
Baltimore,			20a. Method of Disposition 1	lemoval from State	cemetery, cre	esition (Name of matory or other place Park Ce			cation - City or To Ltimore	
Balt	permit. Page Department of Importent: If any injury or		21. Signature of Funeral Service License	ser a		6510-	g Co.,Ir 16th St	NW. Wa	sh.,DC	
	Physician /Medical Examiner	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consection).	PS (Sence of):	er the mode of dying	such as cardiac or	respiratory arrest,	3	Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	Icai	that initiated events resulting in death) Last	Due to (or as a consect.	uence of):					
P.O. Box 6	death certif e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	Il death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause giver	in Part I.	23e. Did tobacco t		ne cause of death?
of Vital Records,	The ete h page	Completed	Dys phagic	pulmostare	dis	ease		24a. Was an autopsy performed?	prior to con death?	osy findings available inpletion of cause of
f Vita	Physicien: Th this certificete ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	Othor	26. Place of Death (Check only one) 5 Residence	6 □Other (Specify	·)
	fing After fune		27. Manner of Death Natural Accident 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work?	at 28	d. Describe how injur		
Division	Hospital or Atteno 24 hours after death Funerel Director: tely filled in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury · At h building, etc. (Specif		eet, factory, office	28	f. Location (Street an City or Town, State		Route Number,
		edical		sician: To the best of my kno ner: On the basis of examina and manner stated.						
	To the within To the comple	Σ	29b. Signature and title of certifier	ll mo		29c. License			rch 29,	
2	2		30 Name and address of person who co Dr.Samuel Malle				ville,Md	. 20850		
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 1 2004	82. Registrar's Signa	ature					
DH	MH 17 Bev 1/2	001		1	1					

		•	For State Registrar	State of Marylar		artment of H			iene	nμ	12277
A.	Physici		Decedent's Name (First, Middle, Last) WILLIAM	RANDOLPH	HOLLA	ND		2. Date of Dea Month MARCH		rear 6	Time of Death
>	/Medic Examin		4a. Facility Name (If not institution, give st PRINCE GEORGES H	reet and number) OSPITAL CENT	ER	4b. City, Town, or CHEVER			4c. County of PRINCE	Death	GES
	Funeral Director		5. Social Security Number 6. Sex 578−66−1405 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (<i>in yrs</i> . M 2□F 54	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth Month, Day Feb. 28	3, 1950	9. Birthplace Country) VIR((State or Foreign
	yland how		Usual Residence of Decedent 10a. State 10b. County D • C •		ty, Town or Lo						Inside City Limits
	r 28a-f s	Director	10e. Street and Number		BILINGIC	10f. Zip Code		1	0g. Citizen of Wh		1 Yes 2 No
	s 23a o		5110 "A" STREET,	S. E. # 4	16 12	20019 Was Decedent of Hi	spanio Origin? (9	Spacify Vac or No.	U. S.	A.	ndian
920	ours after de rai', or item Ever il ver	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 ☐ No		1 ☐ Yes 2 ☐ No	Specify:	to Rican, etc.)	Black,	White, etc. BLACE	
aryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural; or items 23e or 28e-f show is marked other than "natural; or items 20e or 28e-f show aumatic event. It a Medical Examinar must be recitied at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired, JANITOR	furing most of wo	rking	APRT. B		ry
land 2	ould be filed v Mental Hygie varked other t vatic svent. II	To Be C	17. Father's Name (First, Middle, Last) SAMUEL HOLLAND					me (First, Middle, I)	
Mary	od 2 should th and Men 27 is marke traumatic		19a. Informant's Name/Relationship (Type MICHAKA WILLIAM +		19b. Mailii 466	ng Address (Street a	and Number or R GRD., S	ural Route Number • E • _{WA} \$A⊤N	r, City or Town, Si	tate, Zip Cod	de) 20019
timore,	permit. Pages 1 and 2 should Department of Health and Men Important: if item 27 is marke any injury or other traumatic ance.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	mount from State	Place of Dispo cemetery, crei	osition (Name of matory or other place) NATIONAL CEMETERS	9)	Date 01-04	20c. Location - C	ity or Town,	State
Baltii	permit. Popartm timportal any inju		21. Signature of Funeral Service License		36/ 34	Name and Addres	s of Facility W	. H. BACO . WASHIN	ON FUNER NGTON, D	AL HOM	ME, INC.
100	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition	cations that caused the dea	th. Do not ent	ter the mode of dying		c or respiratory arr	est,	Inte	proximate erval Between set and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):						_
	pet list	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	quenca of):					n E	
,820,	icate be executed physician and s the burial-transit	dicai Exar	that initiated events resulting in death) Last	Due to (or as a consec	quence of):						
9	leath certificate attending phy I for use as the	/Medic	IF FEMALE:	3c. If yes, outcome of pregn	ancy				and But	-1 -1 -1	
.O. Box	that the death o ed by the attend detached for us	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Fett 4 Pregnant at time of 6	al death 3	Ectopic pregnancy Other (specify)			23d. Date Monti		/ Year
S, D	quires that n signed b uld be deta	ρ	Part II. Other significant conditions conf	tributing to death but not re	sulting in the u	nderlying cause give	en in Part I.		bacco use contrib es 2 □ No 3	ute to the ca	
Vital Record	The law requires that the death certificate be executed rate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed						24a. Was a autops perforr	y pri med? de	ere autopsy or to comple ath? Yes 2	findings available ation of cause of
Vita	Physician: Th this certificate ral director, pag	o Be (25. Was case referred to medical examiner? 1 Yes No	ospital: 1 ☐ Inpatient	ER/Outpatier	nt 3 DOA Othe	NC.	ath (Check only on		/Speciful	
n of	ling Phy	-	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injury Work	at		ow injury occurred		
Division	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str ify)		fes 2 □ No	28f. Location (SI City or Town	reet and Number n, State)	or Rural Ro	ute Number,
	a Hospital or 24 hours afte Funeral Dir letely filled in I	edical C	29a. Certifier TA Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kn er: On the basis of examinand manner-stated.	owledge, deat ation and/or in	h occurred at the time vestigation, in my op	ne, date and place pinion, death occ	e, and due to the caurred at the time, d	ause(s) and manr ate and place, an	ner as stated d due to the	1. cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	11.0	_	29c. License	number	2	9d. Date signed (Month, Day,	Year)
)	0		30. Name and address of person who con	mpleted cause of death (Ite	m 23a) (Type,	Print)	7001		01	- 0	n/A
	Sta	ite	31. Date filed (Month, Day, Year)	22. Registrar's Sign	(90016)0 ature	is 1405p.	5001 1	405p. D	R. Chel	Ruly	14 a-20785
П	Regist		MAR 3 1 2004	Kee b L		w .					

State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 11:28 p M March 28, 2004 Harry Wesley Henry /Medical 4c. County of Deeth 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 5022 55th Avenue Rogers Height If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1XM 2□F 79 4, 1924 Virginia 226-26-3723 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ns 23a or 28a-f shor 1 ☐ Yes 2 X No Directo Rogers Height Maryland Prince George's 10g. Citizen of Whet Country? 10e. Street and Number 5022 55th Avenue 20781 U.S.A. Funeral death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) of 2 should be filed within 72 hours after deal the and Mental Hygiene.
27 is marked other then "natural", or Items: traumetic event, the Mucilcal Examination. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW II 1 ☐ Yes 2K No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Metro Transit 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harry Wesley Henry Sr. Annie Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Item 27 I 5022 55th Avenue, Rogers Height, Maryland 20781 Beatrice M. Henry - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition ţ 1 X Burial 2.☐Cremation 3 ☐Removal from State = 5 permit. Page Department of Important: If any injury or once. Fort Lincoln Cemetery 4/1/2004 Brentwood, Maryland * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Furniral Septice 144 4739 Baltimore Ave., Hyattsville, MD 20781 alley Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Immediate Cause (Final 2 Days G.I. Bleeding **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed physicien and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Aortic Abdominal Aneurysm Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 🔀 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 NResidence 6 Other (Specify) 1 Yes 2XNo Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 X Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No M investigation death. in by the Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a To the Funerel E pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D38149 March 29, 2004 wan Deagett Whom 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 6525 Belcrest Road, Hyattsville, Maryland 20782 Susan Leggett-Johnson, _MD 31. Date filed (Month, Day, Year)
MAR 3 0 2004 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygienen Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month MARCH 27, HALEM 2004 11:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1925 CHAPEL HILL ROAD SILVER SPRING MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1 / 0 3 / 1 9 3 2 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 71 Director 063-24-8655 NEW YORK Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 X No Funeral Director MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1925 CHAPEL HILL ROAD 20906 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if Itam 271s marked other than "natural; or Items 23s any injury or other traumatic event, the MacCell Examiner must any injury or other traumatic event, the MacCell Examiner must apprie. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE_OFFICER NIH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE LIPPMAN 2 YETTA GOTTHELF 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DR. MILTON HALEM/HUSBAND 1925 CHAPEL HILL ROAD, SILVER SPRING, MARYLAND 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDEN OF REMEMBRANCE 03/28/2004 CLARKSBURG, MARYLAND 21. Dignature & Funeral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC PANCREATIC CANCER 2 1/2 YRS /Medical Due to (or as a consequence of) Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE YEARS Cequentially list curintions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indicated events.) Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown cate has been signed , page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificate 1 ☐ Yes 2 😾 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2 X No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending within 24 hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) M0060335 MARCH 27, 2004 Paul Barner 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL BANNEN, MD 18111 PRINCE PHILIP DRIVE #327, OLNEY, MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 29 2004 Registrar

			1 - For State Registrar AMEND#3, 25 perM	State of Maryla	•	artment of F		•	giene Reg. No. 2 N f	11. 12200
	Physici	an	Decedent's Neme (First, Middle, Last,					2. Date of Dea	ath	3. Time of Death
	/Medic	al	CLAUDIA 4a. Facility Name (If not institution, give	B. HAL	L	4b. City. Town, o	r Location of De	MARCH	20, 20 4c. County of	
	Examin	er	15315 Holly G				er Spri			GOMERY
	Funeral		Social Security Number 6. Security Number	x 7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days	If Under 24 H			Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	60	Yrs.			Feb 7,		Maryland
	yland yland		10a. State 10b. County	10c. C	ity, Town or Lo	cation			-	10d. Inside City Limits
	Ba-f si	Director	MD Montgo	mery	Silv	er Spri	ng			1 ☐ Yes 2 🕵 No
	with the or 2:	Dire	10e. Street and Number 15315 Holly G	rove Road		10f. Zip Code	905		10g. Citizen of Wh	at Country?
	death ms 23	nerai	11. Marital Status	12. Was Decedent Ever in	U.S. 13.			(Specify Yes or No- erto Rican, etc.)	14. Race -	American Indian,
ဓ္တ	filed within 72 hours atter death with the Maryland Hygiene. uther than "natural", or Items 23e or 28e-f show shit, It a Medical Examinar must be notified at	by Funerai	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give		1 ⊡Yes 20© No		eno rican, etc.)	Specify:	White, etc. Black
21215-0036	tural'	ed p	3 XWidowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busin	
215	thin 72 e. en "ne Media	Completed	(Specify only highest grad		life.	kind of work done OO NOT use retired	d)			
7	led will lygien her th	Con	Elementary/Secondary (0-12) 12th			Store M		lame (First, Middle,		Store
Maryland	d be fi	To Be	17. Father's Name (First, Middle, Last) Herbert	Pumphrev					Holland	
ary	shoul and Me mark	F	19a. Informant's Name/Relationship (7)	All and the second seco	19b. Mailir	ng Address (Street		Rural Route Numbe		ate 2.0) 9 .0 0 5
	and 2 ealth a m 27 is			Aunt)			ly Gro	ve Rd, S		
lore	ages 1 to to Miter or otl		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ F	Removal from State	cemetery, crer	sition (Name of matory or other place	· 1	Date	20c. Location - Ci	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23e or 28e-f show may injury or other traumatic event, the Medical Examinat must be notified at once.		*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	122,	22	Cemetr	es of Eacility			Spring, Md
å	Dep Imp any	-	Tente d. y	Insude	u			al Home		0850 ille, Md
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	lications that caused the dea ne cause on each line.	ath. Do not ent					Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		BREAST	CANCE	R		Years
	Examiner			Due to (or as a conse	equence of):					
Q	₽ ≓	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	queпсе of).					
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	auence of):					
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9	rtificate ng phy as the	Aedic	SECOND S.	V						
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0	e + £	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown	death 5	Other (specify)				
S, P.	res that the igned by be detact	by Pr	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribu	ute to the cause of death?
ord	The law requires that ate has been signed b age 2 should be deta	ted t						- 1 Y	es 2 🗆 No 3 [Probably 4X Unknown
Vital Record	: The law r cate has be page 2 sh	Completed						24a. Was a autops perfor	sy prio	re autopsy findings available ir to completion of cause of
a		e Co	25. Was case referred to medical				00 Pt +4 F	1 □ Yes	2 又 No 1□	Yes XXNo
<u> </u>	Physician: this certific ral director,	To B	examiner?	Hospital: 1 ☐ Inpatient 2 [☐ ER/Outpatier	t 3 DOA Oth		eath <i>(Check only or</i> Home 5 ☑ Resid		(Specify)
n of			27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	Wor	y at k?		ow injury occurred	
Division	Attending r death. actor: After	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At	home farm str		Yes 2 □ No	28f. Location /S	tmet and Number	or Rural Route Number,
Οİ	in Little	Certification:	4 Homicide determined	building, etc. (Spec	rify)	ost, ractory, omoo		City or Town	n, State)	or riarar rioute riamoer,
	To the Hospital or At within 24 hours after or To the Funaral Dirac completely filled in by	edical (29a. Certifier Check only one) Certifying Phy 2 Medical Exami	sician: To the best of my kr iner: On the basis of examir and manner stated.	nowledge, death nation and/or in	n occurred at the tin vestigation, in my o	ne, date and pla pinion, death oc	ice, and due to the c curred at the time, d	ause(s) and manne late and place, and	er as stated. I due to the cause(s)
	To th To th compl	Me	29b. Signature and title of certifier	0		29c. Licens	e number	2	29d. Date signed (A	Month, Day, Year)
,	10		1 HEX	In m	7)	D-35	635		March :	23, 2004
			30. Name and address of person who Joseph H. K			*	Phill	ip Dr (Olnev	VI 20832
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature /			- DI) (- 111 - y , 1	20002
	Registr	ar	MAR 29 20	04 Beneva	food	Spark	2			

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Registrar

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		4	For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F ertificate of	lealth and N Death		ene 2 () () g. No.	4 12282
100 mg	Physici		1. Decedent's Name (First, Middle, Last Donna Jean	Hardman				2. Date of Death Month	Day Ye 29	1 1 1 1 10 10 11 11 11
	/Medic Examir	- 4	4a. Facility Name (If not institution, give Doctors Community	Hospital		Lanhar			4c. County of D	George's
D.	Funeral Director		5. Social Security Number 6. Se 235–64–3889 Usual Residence of Decedent	x	(In yrs. last birthday 60 Yrs.) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July3, 1	9. 943 We	Birthplace (State or Foreign Country) est Virginia
	B Maryland	ctor	10a. State 10b. County Maryland Prince G	George's	10c. City, Town or L Lanham	ocation				10d. Inside City Limits 1 ☐ Yes 2 ▼No
	th with the 23a or 28	ai Dire	10e. Street and Number 6415 98th Avenue			10f. Zip Code 2070)6		g. Citizen of What United S	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Morrored	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ XV If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		merican Indian, Vhite, etc. White
Maryland 21215-0036	Jwithin 72 ho piene. r than "netu	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	ucation le completed) College (1-4or 5-	(Giv.	edent's Usual Occup e kind of work done DO NOT use retire Manageme	during most of work d)	ting	6b. Kind of Busine Real E	
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	ind 2 sho alth and I 27 is ma or trauma		19a. Informant's Name/Relationship (7) Courtney A. Hardin			ing Address <i>(Street</i> 5 98th Ave				
Baltimore,	Pages 1 a nent of Hei nt: If item		20a. Method of Disposition 1 XBurial 2 Cremation 3 1 4 Donation 5 Other (Specify,		20b. Place of Disp cemetery, cre Eventide	e cemeter	ce)		oc. Location - City Denoer, Wes	or Town, Stete st Virginia
Balti	permit. Departmitimporta		21. Signature of Funeral Service Licens	Borgera	1 4	2. Name and Addre Donald V. 1400 Powde	אווווו אר	' RAITST	בות בווי	P.A. ryland 20705
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of limediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Hepat Due to for as a Due to (or as a	a consequence of):			or respiratory arre	st,	Approximate interval Between Onset and Death
,8760,	cate be executed physician and the burial-transit	licai	resulting in death) Last	d	consequence of):					
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Ö	To the Hospital or Attencyllin 24 hours after death To the Funeral Director: completely filled in by the	edical Cer	29a. Certifier Certifying Phy (Check only 2 Medical Exam	rsician: To the best o	f my knowledge, dea	th occurred at the time	me, date and place, pinion, death occur	and due to the cau	use(s) and manner	as stated. due to the cause(s)
)	To the I	Med	29b. Signature and total of certifier 30. Nam and address of person who certified to the c	and manner state			e number D 4280		d. Date signed (Me $3/29/c$	• • • • • • • • • • • • • • • • • • • •

State Registrar

Donna Jen Handman

1400 mercantile Lane Largo,

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32. Registrar's Signature

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31. Date filed (Month, Day, Year)
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			1 - For State Registrar 1. Decedent's Name (First, Middle,		Marylan	-	artment rtificate				Reg. No.	200	4 1	2285
> -	Physici /Medic Examin	ai	4a. Facility Name (If not institution, shady Grove Adv	R, ITM				own, or Loc	cation of Deat	2. Date of De, Month	Day 2 9 4c. 0	Yea County of De	ath Y	M
¥.	Funeral Director				Age (In yrs. la		If Under 1	Year If	Under 24 Hrs. ours Min.		h y, Ye <i>ar)</i>	9. E	irthplaca (Star Country) nnesot	_
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ING Z1Z13-UU36 be filed within 72 hours after death with the Maryland	ial hygiene. id other than Inatural; or Items 23a or 28a-f show event, the Mudical Extrafracritat be notified at	Completed by Funeral D	110 Booth Stre 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest telementary/Secondary (0-12)	12. Was Decede Armed Force 1 XYes 2 If Yes, Give Year or Date	PS? □ No 194 ps: 194 pr 5+)	42- 46 16a. Dece (Give life. L	Was Deceder I Yes, specification I Yes 25 Ident's Usual I kind of work DO NOT use	No Sp Occupation done during retired)	pecify: g most of wor	-	16b. Kind	Black, When Black,	nerican Indian, nite, etc. White s/Industry	•
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a _ a	Department of Health Importent: If Item 27 any injury or other trongs.		Christa Harper 20a. Method of Disposition 1 2 Burial 2 Cremation 3 4 Donation 5 Other (Spe 21. Signature of Funeral Service Lie	□Removal from Sta	ite ce	ace of Dispo emetery, cren est Hi	11 Cer	of er place) netery Address of	Apri y 200 Facility De	il 5, 04 EVol Fun	^{20c. Loca} Dulut eral	h, Mi Home	nnesot	a
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ブリ	Sta Registr	30	30. Name and address of person wh MIND O HOW 31. Date filed (Month, Day, Year)	D () 32. Regis	f death (Item:	Shoely	Print)	nd	4 301	8 1 - Roch	21/1	6,171	2001.	10

		•	For State Registrar	State of	of Marylan	•	artment of H				ene 2004	12284		
		+	Decedent's Name (First, Midd.	le, Last)					1	2. Date of Death	1	3. Time of Death		
	Physici		Richard Arthur	Hartio					M	Month Day Year 9:21 A				
	/Medic Examin		4a. Facility Name (If not institutio		ımber)		4b. City, Town, o	or Location			4c. County of Dea	ath		
	LAGIIIII		Washington Adv	entist Hos	spital		Takom	Park			Montgome	rv		
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ē	s 1 and 2 of Health a item 27 is		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of	T	Da		20c. Location - City o	r Town, State		
2	Pages nent of ant: If its		1 Burial 2 Cremation 4 Donation 5 Other (State Geo	orge Wa	matory or other pla shington	Cem.	03/3	1/04 A	delphi, M	D		
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Ba	permit. Pages 1 Department of H Important: If its any injury or ot		Komola-9	= (x)-0								ng, MD 20904		
			23a. Part1. Enter the disease, of	or complications that	caused the deat							Approximate		
			shock, or heart failure. Lis Immediate Cause (Final	t only one cause on	_							Interval Between Onset and Death		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) ANONIC ENCEPHALOPATHY Due to (or as a consequence of):											
	Examiner		Sequentially list conditions b. CEREBROVASCULAR DISEASE											
		ē												
	J Insit	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.											
,	exect n and ial-tra	Exa	resulting in death) Last	Due to	(or as a consec	quence of):								
8760,	cate be executed oblysicien and the burial-transit	dical		L d										
9	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	0												
Вох	leath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		Testania programana				23d. Date of de	alivery		
m	death e atte d for	lcia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg	birth 2 ☐ Feta nant at time of c		⊒Ectopic p regnan c ∃ Other (s <i>pecify</i>) _	У			Month	Day Year		
0	t the de by the tached	hys	9 Unknown	9□ Unki	nown									
٥,	res tha igned l	by P	Part ii. Other significant condit	ions contributing to	death but not res	sulting in the u	nderlying cause gr	ven in Part	1.	23e. Did tob	acco use contribute	to the cause of death?		
ğ	w require been sig should to	ed t	ANEMIA							1 ☐ Ye	s 2□No 3	robably 4 Unknown		
Records,	aw requ s been 2 shoul	Completed	ACUTE ?	ACUTE RENAL FAILURE								utopsy findings available completion of cause of		
Re	The lay	E O								autopsy perform	ed? death?			
Vital		a	25. Was case referred to medic	al				26. Plac	e of Death	(Check only one				
>	Physician: this certificanal director,	0 B	examiner? 1 ☐ Yes 2 2 No	Hospital:	Unpatient 2□	ER/Outpatie	nt 3 DOA Oth	her: 4 🗆 N	ursing Hom	e 5 ☐ Resider	nce 6 Other (Spe	ecify)		
o		E E	27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time o	f 28c. Inju Wo	rv at			w injury occurred	,		
io	Attending F death. ctor: After y the funera	atio	1 Natural 5 Pend 2 Accident inves	ing (Wis	min, buy roury	injury		Yes 2□]No					
Division	or Attencater death Director:	ific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	mined 200. Flat	e of Injury - At h	iome, farm, st	reet, factory, office		28	Bf. Location (Str. City or Town,	eet and Number or F	Rural Route Number,		
ā	s afte	Certification:	T T loss loss	Jan	3mg, 6to. (opea.	.,,,				0.1, 0. 701111	, Siaio,			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune		29a. Certifier Certify.	ing Physician: To th	e best of my kno	owledge, deat	h occurred at the ti	me, date a	nd place, ar	nd due to the ca	use(s) and manner a ite and place, and du	is stated.		
	he H in 24 he F piete	Medical	one)	and ma	nner stated.									
	To t To t	Σ	29b. Signature and title of certifi	0		7	29c. Licens	se number		29	d. Date signed (Mor	th, Day, Year)		
•	5		tous	/ Pare	c M	11	U.	270	3	/	MARCH	30, 2004		
		1		n who completed cau	use of death (Iter	m 23a) (Type,	Print)	-		~	11			
				RCA 79	01 MA.	PLE A	DUENUE	IA	tomp	9 YARK	MARYL	10, Day, Year) 30, 2004 AND 20912		
		ate	31. Date filed (Month, Day, Yea	7) 32.	Registrar's Sign	ature 4	Soonk	2/		,				
9	Regist	rar	MAR 3 1	2004	Jac Jase	100	/-/-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** March 27, 2004 8:15P M Rita Teresa Heany /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Potomac Manor Care-Potomac If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) 5. Social Security Number **Funeral** 1□M 2K)F Washington, DC 89 1914 579-60-7496 May 6, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director D.C. Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or Itams 23a 20015 United States 5420 Connecticut Avenue, N.W. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? within 72 hours after t □Yes 2♥ No It Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced White 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 4 Legal Secretary U.S. Government permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any injury of other traumatic event. 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be injury or other traumatic Thomas J. Heany Grace A. Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7934 Calle Posada, Carlsbad, California 92009 Mary Heany/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 31, 1 Burial 2 T Cremation 3 Removal from State Dethesda, Maryland

22. Name and Address of Facility Robert A.

Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue

M00803 Bethesda, Maryland 20814-3501

The death. Do not enter the mode of dying, such as cardiac or resource. Montgomery Crematorium, Inc. ' 4 Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Service Licende 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Advanced Dementia **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ※No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown cate has been sig. Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No autopsy performed 1 Yes 2X No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No i Director: A investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours at To the Funeral C completely filled i Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0054566 March 29, 2004 30. Name and address of person who completed cause ot death (Item 23a) (Type, Print)

Registrar

State

Sunitha Bhogavilli, M.D.

APR 0 2 2004

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760.

P.O. 1

Division of Vital Records,

32 Registrar's Signature

men

1220 East Joppa Road, Towson, Maryland

Oacks 20

				State of M		Depa	artment of H	lealth and M	lental Hyg	jiene			
			1 - For State Registrar			Cei	tificate of	Death		eg. No. 2	104	122	286
	Physici /Medic		1. Decedent's Name (First, Middle, La Audrey C. Hecker			25, Day 200)4 ^{Year}						
E	Examin		4a. Facility Name (If not institution, gi			-	r Location of Death			4c. County of Death			
			16420 Black Rock		== (l= v= l= s h	lastin atau at	Germant If Under 1 Year	OWN If Under 24 Hrs.	9 Date of Birth		gome		· Comina
	Funeral Director											place (State or ntry) York	roreign
	land ow		10a. State 10b. County		10c. City, Tox	wn or Lo	cation			-		10d. Inside Cit	y Limits
	Many	ģ	Maryland Montgom	nery	Ge	erma	ntown					1 🗌 Yes	2 ☑ No
	or 28	Jre(10e. Street and Number				10f. Zip Code		1	0g. Citizen of	What Cou	ntry?	
	ath wi	ral	16420 Black Rock			1	2087			Jnited			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show singly or other traumatic event, it a Mydical Exercise trausal be redilled at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Tyes 2 If Yes, Give Year or Dates:	?		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☑ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Special	ice - Ameri ack, White, ify: Wh		
5-0	72 hc	etec	15. Decedent's E (Specify only highest gi	ducation rade completed)	168	(Give	dent's Usual Occup kind of work done	during most of work	ing	16b. Kind of B		,	
121	within ane. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			DO NOT use retire. Ling Assi		Montgomer:				
d 2	Hygie Hygie other ant, tr		17. Father's Name (First, Middle, Las	it)				18. Mother's Nam	e (First, Middle,				
an	lid be lental ked c	To Be	Charles		Bar	ho1	1	Mildr	ed Stief	el			
Maryland	and M and M a mar		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,								, State, Zij	Code)	
Σ	and 2 salth a n 27 I		Richard Hecker/Hu	ısband	16	6420	Black Ro	ck Road,	Germanto				4
Baltimore,	Pages 1 nent of He ant: If iten ury or oth		20a. Method of Disposition 1										
Balt	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Lice	ensee	M00198	Ro 300	Name and Addre bert A. West Mor	ss of Facility Pumphrey ntgomery A	Funeral	Home/R kville.	ockvi MD 2	.11e, I:	nc.)5
	Physician /Medical Examiner	resulting in death) Due to (or as a consequence of):							est,		Approximate Interval Betw Onset and D 2 year	e veen Death	
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P.O. Box 6	es that the death certificate igned by the attending phys be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	Ectopic pregnancy Other (specify)	y			3d. Date ol delivery Month Day Year					
	requires that the een signed by th hould be detache	by Pt	Part II. Other significant conditions	contributing to death	but not resulting	in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use con	itribute to t	he cause of de	ath?
rds	w require been sig should b	ed b							1 🗆 Yı	es 2 🙀 No	3 Prot	oably 4 □U	nknown
Records,	ding Physician: The law re h. After this certificate has be funeral director, page 2 shc	Completed		24a. Was a autops perform	med?	Were auto prior to co death? 1 \(\text{Yes} \)	opsy findings a mpletion of ca	vailable use of					
ita	ian: artifica ctor, p	Bec	25. Was case referred to medical examiner?					26. Place of Deat	1				
Š	hysic his ce I dire	To	1 ☐ Yes 2 🔀 No		ient 2 ER/C			4 Nursing Ho	me 5 Reside			'y)	
Division of Vital	Attending Physician: r death. sctor: After this certific by the funeral director,	atlon:	27. Manner of Death 1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigati		ay Year) 28b.	. Time of Injury	Wor	yat rk? Yes 2 □No	28d. Describe ho	ow injury occur	rred		
Divis	in Diffe	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 200. Flace of 11	njury - At home, t etc. <i>(Specify)</i>	farm, str	eet, factory, office		28f. Location (Si City or Town	reet and Num n, State)	ber or Rura	al Route Numb)B <i>f</i> ,
	the Hospital hin 24 hours of the Funeral upletely filled	Medical		Physician: To the bes aminer: On the basis and manner s	of examination a								
	10	Ř	29b. Signature and title of certifier	M. Hag	gerty.	ml	29c. Licens	3240°		9d. Date signe March			
	10		30. Name and address of person who										
			Joseph M. Hagger		9707 Me trar's Signature	dic	al Center	Drive #3	300, Roc	kville,	, Mary	land 2	0850
	Sta	ate	MAND 9 0 20		and dignature	4	Ann V	1					

			. 10000 1	State of Maryland	1 / Dens	rtme	nt of H	ealth a	and M	ental Hyd	niene	3		
			1_ State	State of Ivial yland				Death			Reg. No.	200	1. 12207	
	7. W		Registrar 1. Decedent's Name (First, Middle, Last)							2. Date of Dea	ıth	The Co	3. Time of Death	
	Physicia		David Tolbert	Horton						March 2	Day	Year 2004_	10:45 am	
	/Medic Examin		4a. Facility Name (If not institution, give str			4b. City	, Town, or	Location of	of Death	1102 011		County of Dea		
		, ;	Holy Cross Hos	spital				Spri				ontgom		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day			thplace (State or Foreign ountry)	
	Director		499-12-5883 Usual Residence of Decedent	79_	Yrs.		<u> </u>			April 1	9, 1	924 A1	abama	
0	. A		10a. State 10b. County	10c. City	, Town or Lo	cation							10d. Inside City Limits	
Many	, e	ţ	Maryland Montgome	rv	Silve	r Sn	rino						1 ☐ Yes 2 ☑ No	
Ž.	7.28a	Director	10e. Street and Number	<u> </u>	7119		p Code				10g. Citi	zen of What C	ountry?	
di di	23a o		12726 Feldon Stree	t.			2090					USA		
000	SE DE	Funeral	11. Marital Status	Was Decedent Ever in U. Armed Forces?	S. 13.	Was Deci	edent of Hi ecify Cuba	ispanic Ori n, Mexicar	igin? (Spe 1, Puerto	ecify Yes or No- Rican, etc.)	.	 Race - Am Black, Wh 		
3	Familier must be nutitied at	by F.	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give		1 🗆 Yeş	2 🙀 No	Specify:				Specify: Wh	ite	
books of this discharge of the Manual and	natural',		15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Busin										s/Industry	
1	n na	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of w DO NOT	ork done d use retired	during mos	t of worki	ng				
	ir the	Completed	Elementary/Secondary (0°12)	4	Med	chand	cal	Engin	eer		Fed	eral G	overnment	
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	is m		19a. Informant's Name/Relationship (Typ	e, Print)						al Route Numbe				
î .	permit. Fages 1 and 2 shourd be beatment of Health and Ment important: if Item 27 is marked any injury or other traumatic society.		Christine W. Horton 20a. Method of Disposition	n/ Wife	12/2 lace of Dispo emetery, crei					Silver		cation - City o		
5	nent of h		1 □ Burial 2 ☑ Cremation 3 □ Re	moval from State				1		ch 26,				
,	injury		*4 □ Donation 5 □ Other (Specify) 21. Signature of Fineral Service License		ropol:					004			a, Virginia	
2	Departn Departn Imports any inju		Valore +5k	anses	Fr 50	anci O Un	s J. ivers	Coll:	ins l Blvd.	Funeral	Hom:	e Inc. r Sprin	ng, MD 20901	
6			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused he death	n. Do not ent	ter the mo	de of dyin	g, such as	cardiac d	or respiratory ar	rest,		Approximate Interval Between	
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5	at the	Phys	9 Unknown		Min to M	W 4 *		a ta Bank	-	220 Did to		so contributo	to the cause of death?	
ń	requires that een signed b nould be deta	Completed by Physician/Med	Part If. Other significant conditions cont			, -	_						Probably 4 Unknown	
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	n: The licate har.		Hypothyroidism 25. Was case referred to medical					00 51	4 D4	1 ☐ Yes		1 ☐ Ye	s 2 No	
VII	Physician: The law this certificate has b ral director, page 2 s	o Be	avaminar?	ospital:	FR/Outpatie	nt 3[7][Oth Oth	00		h <i>(Check only o</i> me 5 ☐ Resid		S []Other (Sp.	ecify)	
DIVISION OF	Physer this eral dii	-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		28c. Injur			28d. Describe I			,	
5	tending P feath. tor: After t the funera	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 10al)		М		Yes 2]No					
$\frac{n}{2}$	si or Attending F atter death. I Director: Atter d in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st	reet, facto	ory, office			28f. Location (S City or Tox			Rural Route Number,	
2	ital o irs aft ral Di													
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, deat tion and/or in	th occurre nvestigation	ed at the tir on, in my o	ne, date as pinion, des	nd place, ath occuri	and due to the red at the time,	cause(s) date and	and manner a place, and du	is stated. le to the cause(s)	
	thin 2 the of the	Med	29b. Signature and title of certifier	and mainer stated.		2	9c. Licens	e number		-	29d. Dat	e signed (Mor	nth, Day, Year)	
	F 3 F 8		X MILLON	and harden	. 1/	2	DOO	57630)		10	larch 2	4, 2004	
	U		30. Name and address of person who cou	mpleted cause of death (Item	n 23a) (Type,	Print)	200	_ , 550			r.	arch 2	7, 4004	
			Anuradha Arun M.D.	10301 Georg	gia Av	enue	Sil	ver S	prin	g, MD	2090	2		
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture 4		aks		-					
	Regist	rar	MAR 2 9 2004	C. Prance	/	KHO	man	P						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Dey} 2004 April 6, **Physician** 8:47 PM Sigridur Ε. Harris /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Prince George's AAFB Malcolm Grow Medical Center Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Min. Months 1 □ M 2 ₩ F 577-94-9255 72 Aug. 5.1931 Director Iceland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location or than "natural", or Items 23s or 28s-f show the Medical Examiner must be nutified at 1 TYes 2 No Director Maryland Prince George's Camp Springs 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5609 Auth Road 20746 U.S.A. Funerai filed within 72 hours after death 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home t. Pages 1 and 2 should be filed rtment of Health and Mental Hygirlent: If Item 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Erlendur Sigurosson Guorun Halfdanardottie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8104 Silver Fox Way ChesapeakeBeach, Maryland 20732 Judy L. Foxx (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition April 9. 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 3 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or once. Lee Crematory Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Furreral Service Lic. - e 6633 Old Alexandria Ferry RD Clinton, MD 20735 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hemorphay Pnysician Upper 61 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed use as the burial-tran and Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ō in the past 12 months?
1 □ Yes 2 ☑ No
9 □ Unknown 4 Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 ANO 25. Was case referred to medical 26. Place of Death Check on one examiner? Hospital: 1 Inpatient 2 XX R/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2XXNo Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. To the Hospitel or Attendia within 24 hours after death. To the Funeral Director: A investigation 2 Accident in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of CIZI. D6659658 4/7/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John Lee, M.D. 6104 01d Branch A 6104 Old Branch Avenue Temple Hills, MD 20748 31. Date filed (Month Pray, Year) 2004 32. Signature State Registrar

			For State Registrar	State of M	faryland /	Depa Cer	rtment of H	lealth and M Death		giene Reg. No. 2 ()	04	12289	
	Physicia		1. Decedent's Name (First, Middle, Lass Mildred Evelyn H.	,					Date of Dea Month	ith Day	Year	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number			4b. City, Town, or Hager	r Location of Death	MARCH	4c. County			
	uneral irector		5. Social Security Number 6. Se		age (In yrs. last b	rirthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day Oct. 16	Yeer)	9. Birthp	place (State or Foreign oftry) Yland	
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with the A	Sa or 28e-	Director	10e. Street and Number 913 Armstrong Ave			ager	Stown 10f. Zip Code 21	740		log. Citizen of t			
Baltimore, Maryland 21215-0036 permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	of, or items 2.	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Yes 2 X If Yes, Give Year or Dates	? Î No	1	/as Decedent of H Yes, specify Cuba □ Yes 2፟፟ No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rac	e - Americ ck, White,		
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timore Pages 1	tant: If Ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		e cemete	ery, crem	ation (Name of atory or other plac 1 Cemete	θ)		20c. Location - Hagers	•	wn, State Maryland	
Ba Permil	Impor any in QDCe.		21. Signature of Funeral Service Licens	70/1	ime	14		son Blvd.		stown,		21740	
/M	sician edical miner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and De disease or condition resulting in death) Due to (or as a consequence of):										
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To the	To the	ž	29b. Signature and title of partifier	20			29c. License	number 55554	29	ed. Date signed	(Month, D	ay, Year)	
5H	3		30. Name and address of person who co	tam III	10 mes	(Туре, Р <i>) і Ç</i>		Pus pu	£1431	taceros	مسم	1	
0.00	Stat Registra	.е	31. Date filed (Month Day Year) 2	04 32. Regist	rar's Signature	do	Les						

			1 - State Registrar	State of Marylar		artment rtificate				Reg. No	0001	12290
	Physici /Medic	cal	Decedent's Name (First, Middle, Last) Joseph Roger H Aa. Fecility Name (If not institution, give s	owell		45 Cit. T		and the of D	2. Date of Month	h á	19, 200	
	Examin	ier	Washington Count 5. Social Security Number 6. Sex		last birthday) Yrs.	If Under 1	lage Year	rstown If Under 24 H Hours N	frs. 8. Date of		Q Bir	hington thplece (State or Foreign ounity) Virginia
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Maryland 2	be filed ital Hygi of other event,	To Be Co	17. Father's Name (First, Middle, Last) Lee Hampton How				1	Neve		a Go	ins	
Baltimore, Mar	permit. Pages 1 and 2 should Department of Health and Men important: If item 27 is marke eny injury or other traumatic ance.		19a. Informant's Name/Relationship (Type William Howell — 20a. Method of Disposition 1XX surial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify). 21. Signature of 5 ineral Service Len	Son 20b. F	P.O. Place of Disponentery, crem Paul 22 05	Box Sistion (Name natory or other sides Cemes Name and sides Cenes Sides Sides Cenes Sides Sides Cenes Sides	900 of place) etery Address Func	Funks y Apr of Facility eral H	town, Man	Clea	ocation - City or ar Sprin	34
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			For State Registrar	State of I	Maryland /		artment			and Me		iene	11111	1229	
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	neral ector				Age (In yrs. last	birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Jul. 16	Yeer)		plece (State or Forei ntry)	gn
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-\$v_			30. Name and address of person 31. Date filed (Month, Day, Year)	PAZE 41	t death from 23	a) Type	Printy	Ro	AD:	#30	DAN	M	Mas u	102140)	
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			1 - For State Registrar	State	of Maryl		artment of F		nd Mer		giene Reg. No. 2	004	12292
			Decedent's Name (First, Mide	dle, Last)					2.	Date of Dea Month		Year	3. Time of Death
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a Z	shoul	^L	19a. Informant's Name/Relation	nship (Type, Print)		19b. Mail	ing Address (Street	and Number o	or Rural Ro	oute Number	r, City or To	wn, State, Zip	c Code)
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DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 286 Plac	e of Injury - / ling, etc. (Sp	At home, farm, st	reet, factory, office	1	28f.	Location (Sti City or Town	reet and Nu n, State)	umber or Rura	d Route Number,
	he Hospii in 24 hour he Funer pletely fill	edical	29a. Certifier (Check only one) Certify	ing Physician: To th Il Examiner: On the t and mar	e best of my basis of exam ner stated.	knowledge, dea nination and/or in	th occurred at the time to the time time to the time t	ne, date and p pinion, death o	lace, and occurred a	due to the ca t the time, da	ause(s) and ate and plac	l manner as si ce, and due to	tated. the cause(s)
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			30 Name and address of perso	n who completed cau	se of death	(Item 23a) (Type	Print) WENSBURG	Ral	40	ittsvi	lle M	10207	181
	Sta Registr		31. Date filed (Month, Day, Yea MAR 3	1 0004	Registrar's S	ignaturo ,	pour		•				

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year MARCH 25, 4:10P ISAACSON 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6111 MONTROSE ROAD, APT. 625 ROCKVILLE MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year)
SEPT 15, 1918 MASS **Funeral** 8. Date of Birth (Month, Day, Year) Months 1 ☐ M 2 ☐ XF Days Hours Director 012-14-2787 85 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examinate must be notified at 1 Yes 2 No Directo MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 6111 MONTROSE ROAD, APT. 625 20852 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after a and Mental Hygiene. Black White etc. ☐Yes 2XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: WHITE à Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 REGISTERED NURSE NURSING permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important; If itam 27 is marked other any injury or other traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOSEPH TITELMAN JENNIE WEINER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACOUELINE A. GLADSTONE. DTR. 11406 TANBARK DRIVE, RESTON, VIRGINIA 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 2004 cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) KING SOLOMON MEM PK MARCH 29, DEDHAM, MASSACHUSETTS 21. Signature of Funeral Service Licensee once. DANZANSKY-GOLDBERG MEMORIAL CHAPELS, 1170 ROCKVILLE PIKE, ROCKVILLE, MARÝLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ACUTE MYELOID LEUKEMIA 3 MONTHS resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760 physician Physician/Medical use as ding IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery atten 3 DEctopic pregnancy detached for Month Day 4 Pregnant at time of death 5 Other (specify) the Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2X No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? 1 Yes 2 No 2 No 1 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) Hospital: 2 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a 29a. Certifier 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Joseph m. Hoggerty mi) D32407 MARCH 26, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20850 JOSEPH M. HAGGERTY, M.D., FACP 9707 MEDICAL CENTER DRIVE, SUITE 300, ROCKVILLE, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature oaks 29 2004 Registrar

Registrar

State

31. Date filed (Month, Day, Year)
APR 0 9 2004

32 Registrar's Signature

frede

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Benita Jones 1- For Unpend Item#23a, Part II,27,28a-f, Per ME 130,4/28/168 12295 04 - 2275AKG 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 12:52 P M 2 Benita Jones April 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Port Deposit

| Funder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Min. | May 29,1962 20 North Main Street Apt. 13 7. Age (In yrs. last birthdey) 5. Social Security Number Birthplace (Stete or Foreign Country) 6. Sex **Funeral** 1 □ M 2 1 F Months 170-54-2857 41 Pennsylvania Director Usual Residence of Decedent 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits "natural", or itams 23a or 28s-f ehow olical Examiner cutst be notified at 1 XYes 2 No Director Cecil Maryland Port Deposit 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21904 United States 20 North Main Street, Apartment 13 Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene and History I file marked other then "natural; or than uny or other traumatic avent, IIIs Musical Enginieury or other traumatic avent, IIIs Musical Enginieury 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Rusiness/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Custodian Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ralph L. Jones, Jr. Marie Curry 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Celestine Hall/Sister 2 Pine Avenue, Elkton, Maryland 21921 20b. Place of Disposition (Name of cometery, crematory or other place)
Trinity 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State

4 □ Donation 5 □ Other (Specify) April 8, permit. Page Department of important: If any injury or North East, Maryland Cemeterv 2004 21. Signature of Fundamental Ce Lice 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 23a. Part Center the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Mixed Drug(doxepin and metaprolol) and Alcohol Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter U. darfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-ti Due to (or as a consequence of) Box 68760. Completed by Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ő in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) P.O. ed by the detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 U⊓known Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Hypertensive Cardiovascular Disease 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ es 2 ☐ No 24a. Was an page 2 certificate 1 XYes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1XXes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: $_{4}\square$ Nursing Home $_{5}\square$ Residence & 20ther (Specify) at scene 2 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural unknown 1 ☐ Yes 2 XNo death. found 4/2/04 2 Accident found 12:35p after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 20 North Maine St., Apt.13, Port Deposit determined 4 Homicide found at home within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Treenkers Joska MO O.C.M.E. April 3, 2004 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) Greenberg M.D Z Tasha 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 7 2004 APR 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2004 29. 10:45 P Foster Lee Jones March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Prince George ManorCare of Largo Largo If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** 1 XM 2 ☐ F 20, 579-10-0893 85 Sept. 1918 Virginia Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow th and Mental Hygiene. ?? is marked other than "natural", or Itams 23s or 28s-f show traumatic event. Its Medical Examina must be notified at 1 X Yes 2 No Maryland Prince George Clinton Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5912 Woodland Lane 20735 death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "natural", or Itam any injury or other traumatic event, the Medical Exercitations. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Plumber Plumbing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ernest Jones Sarah Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Tammy Mulloy/Daughter 1670 Plum Point Rd., Huntingtown, MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 4-2-2004 Brentwood, Maryland * 4 ☐ Donatioo 5 ☐ Other (Specify) 22. Name and Address of FacilityFort Lincoln Funeral Home 21. Signature of Funeral S \$401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Arteriosclerotic Cardiovascular Disease Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Mac Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Injury Division 5 Pending s after death.
I Director: Al 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours are To the Funeral Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 1, 2004 D-18545 s of person who completed cause of death (Item 23a) (Type, Print) 30. Name a Phillip Wisotsky, M.D. 12070 Old Line Center, #207, Waldorf, MD 20602 31. Date filed (Month, Day, Year) 2. Registrar's Signature State APR 0 2 2004

DHMH 17 Rev 1/2001

Registrar

			_ For	State of Mar				-	giene	·
		,	1 - State Registrar		Ce	rtificate of	Death	F	leg. No. 20	04 1229.
	Physici	20	1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month		3. Time of Death
	/Medic		Paul F. Jones						31, 2004	2:20 p M
F	Examin	er	4a. Facility Name (If not institution, giv				or Location of Deat	h	4c. County of	
			4013 37th Street 5. Social Security Number 6. S		In yrs. last birthday)	Mount R		8. Date of Birth	9	George's
	Funeral Director			3.1	70 Yrs.	Months Days	Hours Min.	Jan. 1	1934	Birthplace (State or Foreign Country) Tennessee
	pr ,		Usual Residence of Decedent		Oc. City, Town or Lo					
	ehov	5	10a. State 10b. County Maryland Prince	George's		Rainier				10d. Inside City Limits 1 X Yes 2 No
	28e-f	Director	10e, Street and Number	000180		10f. Zip Code			10g. Citizen of Wha	
	3e or		4013 37th Stree	t		1000	20712		U.S.	
	death	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H	Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or No-		American Indian,
9	or ite	y Fu	1 Never Married 2 Married	1 XYes 2 No If Yes, Give Year or Dates: K(<u> </u>	1 ☐ Yes 2 ☒ No		ornoan, otc.)	Specify:	White, etc.
000	within 72 hours after death with the Maryland one. than "netural", or items 23e or 28e-f ehow the Madical Examil art must be tradified at	ed by	3 XWidowed 4 ☐ Divorced 15. Decedent's E			dent's Usual Occup	nation			White
7	in 72 n "nei hadic	piete	(Specify only highest gra	ide completed)	(Give	kind of work done DO NOT use retire	during most of wor	rking	16b. Kind of Busin	ess/industry
212	d with giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Owne	r & Opera	ator		Good Humo	or Ice Cream
Maryland 21215-0036	al Hyg	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Nar	ne (First, Middle,	Maiden Sumame)	
yla	Ment Markec	7	Frank David	Jones					dscaff	
Mar	12 sh h and 7 is m treum		19a. Informant's Name/Relationship (**					r, City or Town, Sta	
	1 and Healt em 2		Mary Fields - Da 20a. Method of Disposition		20b. Place of Dispo		ceet, Mou	-	er, MD 2 20c. Location - Cit	20712 v or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural; or items 23e or 28e-f show appriants of items 23e or 28e-f show appriants or other treumatic event, the Mudical Examinat man be notified at ancie.		1 Burial 2 Cremation 3 C	memovan nom state	cemetery, crei Monte Vista	matory or other pla Memorial I	cs) Park 04/0	5.1		
al E	mit. F partm portar / injui		21. Signature of Furnital Service Licei						neral Ho	
m	Depared Important Importan		Tout!	Vac					sville,	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	e death. Do not ent	ter the mode of dyir	ng, such as cardiad	or respiratory arr	est,	Approximate Interval Between
Às.	Physician		Immediate Cause (Final disease or condition resulting in death)	Arterios	sclerotic	Cardiova	scular D	isease		Onset and Death Years
	/Medical Examiner		resulting in dealth)	Due to (or as a c	consequence of):					
	*	ē	Sequentially list conditions: if any, leading to immediate	b. Due to (or as a c	consequence of):					
	d d ansit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	6						
Ó	te be executed ysician and ie burial-transit		resulting in death) Last	Due to (or as a c	onsequence of):					
8760,	that the death certificate be executed ed by the attending physician and detached for use as the burial transit	dicai		d						
89 x	ding b	/Me	IF FEMALE:	23c. If yes, outcome of	nregnancy					
Вох	atten atten I for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 (4 Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)	у		23d. Date of Month	Day Year
o.	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	1 Yes 2 No 9 Unknown	9□ Unknown						
o. O.	w requires that been signed b should be det	by P	Part II. Other significant conditions of		not resulting in the u	nderlying cause giv	ven in Part I.			te to the cause of death?
Vital Records,	equire en sig ould b	ted	Mesenteric Thro	ombosis				1 🗆 Y	es 2□No 3□	Probably 4 AUnknown
ecc	ne law r has be ge 2 sh	Completed	Dysphagia					24a. Was a autops	y prior	e autopsy findings available to completion of cause of
= E	: The cate h	ပ္ပ						perform 1 Yes	ned? deat	h? Yes 2□ No
Vit.	Physician: The this certificate har director, page	Be	25. Was case referred to medical examiner?	Hospital:		Oth		th (Check only on		
	Phys r this ral di	7	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatier 28b. Time of				ence 6 Other (Specify)
lon	Attending it death. ector: Alter by the funer	atior	1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Y	ear) Injury	Wor	rk? Yes 2 □ No		, , , , , , , , , , , , , , , , , , , ,	
Division of	ar dear dear dear dear dear dear dear de	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Injury building, etc. (- At home, farm, str	eet, factory, office	10	28f. Location (St City or Town	reet and Number o	r Rural Route Number,
ā	ital or irs aft rat Di									
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 X Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of r	tamination and/or in	n occurred at the tir vestigation, in my o	me, date and place pinion, death occu	, and due to the carred at the time, d	ause(s) and manne ate and place, and	or as stated. due to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated	J	29c. Licens	e number	2	9d. Date signed (M	Ionth, Day, Year)
	H 3 H 8		10 Rul	an de	Virla.	DO DO	1852		April 1,	•
D	_ (U)		30. Name and address of person who	completed cause of deat	h (Item 23a) (Type,	Print)				
1			Paul A. DeVore,			Hyattsv	ille, MD	20781		
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 2 2004	2. Registrar's	Signature	. e.				

			For State Registrer	State of Marylan		artment rtificate			and Me		giene Reg. No	2001	12298
	Physici	an	1. Decedent's Name (First, Middle, Las						2	2. Date of Dea Month	ath Day	y Year	3. Time of Death
,	/Medic	al	Emma Jean Johns 4a. Fecility Name (If not institution, give			4b. City.	Town, or	Location o	of Death	MA,CCI		County of Dea	
	Examin	er	Doctor's Communi			_	nham					-	eorge's
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. 5	• •	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birt (Month, Day 11/03/			rthplace (State or Foreign ountry)
	Director		577-58-8044 'Usual Residence of Decedent	<u> </u>	O TIS.	ll				11/03/.	1945	Was	shington, DC
	72 hours after death with the Maryland neturel', or Items 23a or 28e-f show dical Examinar must be notified at	_	10a. State 10b. County		y, Town or Lo	cation							10d. Inside City Limits
	he Ma 28e-f s	ecto	MD Prince G	eorge's	Gr	eenbe					10 000		1 ∑Yes 2 □ No
	y within 72 hours after death with the Marylan jiene. r than "neturel", or Items 23a or 28e-f show the Medical Examinar must be notifiled at	Funeral Director	10e. Street and Number 9338 Edmonston Rd	. #304		10f. Zip	Code 2077()		1	-	izen of What C ced Sta	*
	death	nera	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. \	Was Deced	lent of His	spanic Orig	gin? (Spec	ify Yes or No- ican, etc.)	-	14. Race - Am	
36	s after , or Ite	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ※ Divorced	1 ∐Yes 2 X No If Yes, Give		1 ☐ Yes 2		Specify:	, 1 00110 111	ican, 6(c.)		Specify: B.	
9	2 hour eturei	ted b	15. Decedent's Ed	Year or Dates: ucation	16a. Deced	dent's Usua	I Occupa	ation			16b. Ki	ind of Business	
215		Completed	(Specify only highest grades) Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	life. I	kind of wor DO NOT us	e retired))				ivate	,
121	e filed within II Hygiene. other than "		11th 17. Father's Name (First, Middle, Last)		Real	Estat	te Re			ive First, Middle,			
and	e da la e	To Be	Julian Bailey						erta	Bag1		Sumame)	
Maryland 21215-0036	s 1 and 2 should be f Health and Menta ftem 27 Is marked other treumatic ev	+	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address	(Street a					r Town, State,	Zip Code)
	1 and 2 Health em 27 I	7.	Tanya Hicks/ Daug			Coope				-		MD 2078	
Baltimore,	@ O		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □		lace of Dispo			9)	Dai	-		ocation - City or	
量	그 돈 뿐 글		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen 		lingto			s of Facility		/2004 . Jenk	L1 ins	llingto Funeral	on, NC
B	Depa Impo any Ir		K. D. Marsh	200								MD 2078	
>	Physician /Medical Examiner	1	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Due to (or as a consequence) Due to (or as a consequence)	uerice of):	er the mode	of dying	g, such as o	cardiac or i	Tespiratory are	rest,	26	Approximate Interval Between Onset and Death
x 68760,	death certificate be executed e attending physician and id for use as the burial-transit	/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of the consequence o	uence of):								
P.O. Box		Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Unknown	Ideath 3□	Ectopic pre Other (spe					2	23d. Date of de Month	livery Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of	intributing to death but not resu	ulting in the ur	nderlying ca	luse give	n in Part I.			bacco u es 2[o the cause of death?
Vital Records,	The ate ha	Completed								24a. Was a autops perform	sy	24b. Were as prior to death?	utopsy findings available completion of cause of 2 \(\subseteq \text{No} \)
	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatien	t 3 DO	Otho			Check only or		S □Other (Spe	
ion of	ding n. After fune	ertification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Bc. Injury Work	4 LI NUI	28	d. Describe h			ciry)
Division		O	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	/) 					City or I owi	n, State))	ural Route Number,
	# 는 # 를	Medical	29a. Certifier (Check only one) 2 Medical Examone) 29b. Signature and title of certifier	vsician: To the best of my knowiner: On the basis of examinat and manner stated.	wledge, death tion and/or inv	estigation,	in my opi	inion, death	d place, and h occurred	at the time, d	late and	place, and due	to the cause(s)
	viil cor		> John	Hong 1	M	-	D	3392	83	2	5 Dall	e signed (Mont	2004
1			T	bmpleted cause of death (Item	575	MAIN	570	1887	- 501	TE 35	14	AUREL,	MS 20707
	Sta Registr		MAR 2 9 2004	2. Registrar's Signal	hon	E							

DHMH 17 Rev 1/2001

JEHNSON, ENMY

				of Maryland / Dep	artment of Health and Natificate of Death	Mental Hygi	•	12200
			Hegistrar Decedent's Name (First, Middle, Last)		Timeate of Death	2. Date of Death		3. Time of Death
	Physici		Thelma Louise Je	efferis		March 24	Day Year	11:05 P M
	/Medio Examir		4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of Death		4c. County of Death	11.031
			Suburban Hospital		Bethesda		Montgomer	У
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2图 I	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, May 16,	Year) 9. Birthp Coun 1921 Mary	lace (State or Foreign try) 1 and
	and **		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town or Li	ocation		1	0d. Inside City Limits
	ne Maryli 8a-f sho	Director	Maryland Montgomery	Silver Sp	ring			1 ☐ Yes 21 No
	with the or 2		10e. Street and Number 3544 Chiswick Court		10f. Zip Code 20906		g. Citizen of What Coun	•
	eath ns 23	erai		ecedent Ever in U.S. 13.			United Stat	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than *natural; or items 23e or 28e-f show amounts in Item 27 is marked other than *natural; or items 23e or 28e-f show any july yor other traumatic event. It a Medical Exercites frault be rediffed at once.	by Funeral	1 Never Married 2 Married 1 Yes,	Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ₭ No Specify:	Rican, etc.)	Black, White,	
Baltimore, Maryland 21215-0036	nin 72 ho In *natura Medical E	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Colleg	ed) (Give	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ring	6b. Kind of Business/Inc	lustry
2	giene giene er tha	Com	<u> </u>		Homemaker		Own Home	
D	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)			e (First, Middle, Ma		
yla	Ment Ment arke	Lo	James Edgar Linton			len Wayso		
, Mar	and 2 sh salth and n 27 is m er traum		19a. Informant's Name/Relationship (Type, Print) Jill J. Trainer/ Daught		ng Address <i>(Street</i> and <i>Number or Rui</i> Old Chester Court			
ore	THE TOTAL		20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from	20b. Place of Dispo	osition (Name of matory or other place) nery	Date 20	Oc. Location - City or To-	wn, State
Ĕ	Pag ment ant:		*4 □ Donation 5 □ Other (Specify)	Crematori	um, Inc. 2004	В	ethesda, Ma	ryland
Ball	permit Depart Import any in		21. Signature of Funeral Service Licensee	M00689	2. Name and Address of Facility Rolethesda—Chevy Chas Bethesda, Ma	ert A. P se, Inc. aryland 2	umphrey Fur 7557 Wiscon 0814-3501	eral Home/ sin Avenue
Č.	Physician [®]		23a. Fart 1.E to the disease, or complications the speck or sant failure. List only one cause of Immediate C mue (Final	at eauced the death. Do not ent in each line.	ter the mode of dying, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due	diopulmonary A to (or as a consequence of):				Inutes
	3	er	Sequentially list conditions.	cardial Infarc to (or as a consequence of):	ELOII			lays
	executed n and at-transit	Examiner	triat initiated events	to (or as a consequence of):				
68760,	cate be physicia s the bur	cai	d					
O. Box (The law requires that the death centificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	egnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	y Day Year
s, P.O.	uires that the de signed by the a d be detached	by Ph	Part II. Other significant conditions contributing to	o death but not resulting in the u	inderlying cause given in Part I.	23e. Did toba	cco use contribute to the	cause of death?
ord	w require been sig should t	eted					2½ No 3 ☐ Proba	bly 4 Unknown
		Completed	25. Was case referred to medical			24a. Was an autopsy performe	prior to com death?	sy findings available pletion of cause of
>	Physician: r this certific ral director,	o Be	examiner?	Inpatient 2 ☐ ER/Outpatien	Other	Check only one	ce 6 Other (Specify)	
Division of	Jing Afte fune	tion: T	The state of the s	te of Injury 28b. Time of Injury Injury		28d. Describe how		
Divis	7 7 7 5	Certification:	a Could not be	ace of Injury - At home, farm, str ilding, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
	To the Hospital of within 24 hours at the Funeral D completely filled in	Medical C	(Check only 2 Medical Examiner: On the	the best of my knowledge, death basis of examination and/or invaner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner as sta and place, and due to t	ted. he cause(s)
	withii comp	Ĭ	29b. Signature and title of certifier		29c. License number	29d	. Date signed (Month, D	ay, Year)
	15		I Jack Un-		D60887	Ma	rch 25, 200	14
			30. Name and address of person who completed ca					
			Jack Flyer, M.D. 5530		ue, Chevy Chase, M	aryland 2	20815	
	Sta Registr		31. Date filed (Month, Day, Year) 32 MAR 2 9 2004	Registrar's Signature	Sparker			

	_	- State Registrar				rtificate d	f Health and of Death	,	Reg. No	Z 1111b	. 400	-
cia	n	1. Decedent's Name (First, Middle, L Conley M.	Jones					2. Date of De Month March	ath 26	200 ^{Year}	3. Time of Death 2:05 P	
dica nine	_	4a. Facility Name (If not institution, gr	ve street and number)				n, or Location of Dea	th		County of Deat		
		805 Lynn Court					ville	1.5.		Montgome		
		212-24-4289	Sex 7. Age 1 X M 2 ☐ F	9 (In yrs. Ia 76	Yrs.	If Under 1 You Months Da			y, Year) 3 192	27 Vir	hplace (State or Fore untry) ginia	ign
	- L	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Lim	its
	ا ف	Maryland Montgo	mery	Roc	kvill	2					1 ☐ Yes 2 🔯 1	VO
	le l	10e. Street and Number		-		10f. Zip Coo	ie		10g. Cit	izen of What Co	ountry?	
	ie	805 Lynn Court	,			208			-	ted Sta		
1	To Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent I Armed Forces? 1 X Yes 2 1		TT	Was Decedent If Yes, specify (1 ☐ Yes 2 🔀	of Hispanic Origin? (s Cuban, Mexican, Puer No <i>Specify</i> :	Specify Yes or No to Rican, etc.))-	14. Race - Ame Black, White Specify: T:	e, etc.	
	Q D	3 Widowed 4 Divorced	Year or Dates:		16a Daga	dent's Usual Oc			105 1	W	Thite	
	iete	15. Decedent's I (Specify only highest g	rade completed)		(Give	ient's Usual Od kind of work do DO NOT use re	one during most of wo	irking		ind of Business/ gomery		
	mo	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Assist	ant Di	rector of Maintenanc	Δ	ļ.	ic Scho		
	e C	17. Father's Name (First, Middle, Las	st)		ULVIS.	LUIT VI		me (First, Middle			,010	
	<u>ල</u>	Henry B. Jones					Betty A	nne Hamn	nond			
		19a. Informant's Name/Relationship			19b. Mailii	ng Address (Str	reet and Number or A	ural Route Numb	er, City o	r Town, State, 2	Zip Code)	
	Jaj-	Ruth A. Jones	/ Wife			Lynn Co		ille, Ma				
		20a. Method of Disposition 1	☐Removal from State	20b. Pla	ace of Dispo metery, crei	sition (Name o matory or other		rch 31,	20c. Lo	ocation - City or	Town, State	
		*4 □ Donation 5 □ Other (Spec	cify)	Par			al Park	2004			Maryland	
		21. Signatura of Funera Service Lice	ensee	-				eVol Fun			20077	
-	-	Son Francisco	Talianting that aguand	d the death			er Park Di			ourg, M	Approximate	
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		Immediate Caus (Final disease or condition resulting in death)	a. Pneumon								Two Days	
		Todaking in addition	Due to (or as	a conseque	ence of):							
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		if any leading to immediate			ence of):							
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ľ	e e	cause. Enter Underlying Cause (Cleader of Injury) that initiated events resulting in death) Last	d	a conseque	ence of):	□Ectopic pregn. □ Other (specif)				23d. Date of del Month	ivery Day Year	
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		•	For State Registrar	State of Mai	rylan				ealth a Death		lental Hy		200	L	1230	
	Physici		1. Decedent's Name (First, Middle, Las Margaret Jennings	1)							2. Date of De Month March	Day	2004	ear	3. Time of Death 7:10P	
	/Medio Examin		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of	of Death		4c.	County of	Death		
			Shady Grove Adven					kvi1					lontg	omer	У	
	Funeral Director		089-24-2231	X 7. Age	(In yrs. 91	last birthday) Yrs.	Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di April 2)	rth ay, Year) 7, 19	12	Birthpl Coun Engl	ace (State or Fore try) and	aign .
	yland sow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10	Od. Inside City Lim	nits
	Marie 1	ctor	Maryland Montgome	ry	Ge	rmanto	wn					-			1 ☐ Yes 2 🔀	No
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural" or Itams 23e or 28e-f ehow important: if Item 27 is marked other then "natural" or Itams 23e or 28e-f ehow any injury or other treumatic event, Ita Medical Evantral must be multipled at once.	by Funeral Director	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:			vvas Dece If Yes, spe 1 ☐ Yes		n, Mexicar Specify:	n, Puerto	ecify Yes or N Rican, etc.)	D-		White,	etc.	
9	2 hou	ted	15. Decedent's Ed	ucation		16a. Dece	dent's Usu	al Occupa	ation	A mdmdvi		16b. Ki	nd of Busin	ne <i>s</i> s/Inc	lustry	
21215-0036	thin 7 e.	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	ise retired	during mos)	t or worki	ng					
	ygien ygien her th		12			Secre	tary		10 Moths	aria Mana	(First, Middle		minis	tra	tive	
Maryland	ntal H ed otl	Be	17. Father's Name (First, Middle, Last) William Eustace W.	John Jonnir	200						avis	, Maideri	Sumame)			
Ž	should nd Me mark mark	은	19a. Informant's Name/Relationship (7		ıgs	19b. Mailir	ng Addres	s (Street a			I Route Numb	er, City o	r Town, Sta	ate, Zip	Code)	
	nd 2 salth ar		Andrew J. Cronin/	Friend		15501	Rive	er Ro	ad, (Germa	antown,	Mar	y1and	208	374	
Je,	of Heal		20a. Method of Disposition	D	20b. P	Place of Dispo	sition (Na	me of other plac	e) [priĺ	Date),	20c. Lo	cation - Ci	ty or To	wn, State	
Ē	Page ant: If		1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		Mor	nocacy			1	200	4				Marylan	
Baltimore,	permit. Departitimport. eny inj.		21. Signature of Funeral Service Licen)135	3 Ro	2. Name a CKVI CKVI	lle, Lle,	Inc. Mary	300 1and	West M 20850-	Pump lontg 2805	hrey omery	Fund Av	eral Home enue	e/
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused to one cause on each line a. Cardiomy of Due to (or as a	opat	hy	ter the mod	de of dyin	g, such as	cardiac c	or respiratory a	arrest,		r	Approximate Interval Between Onset and Death Iwo Years	
3760,	ate be executed The particle and The burial-transit	icai Examiner	Sequentially list conditions, if any leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	consiso	шьпсе .f):										
.O. Box 68	death certifics e attending ph id for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Feta	I death 3	∃Ectopic p ∃ Other (s					:	23d. Date of Month		ry Day Year	
rds, P	tuires that n signed b uld be deta	þ	Part II. Dther significant conditions of Hypertension	ontributing to death bul	not res	ulting in the u	nderlying	cause give	en in Part I						e cause of death? abiy 4∭Unkno	
Records,	The law requires that the ete has been signed by the page 2 should be detache	Completed	Organic Brain Sy	ndrome							24a. Was auto perfi 1 🗆 Yes	psy ormed?	prio	or to con	osy findings availa npletion of cause	ble of
Vital		BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only					
of V	y	10	1 ☐ Yes 2 📉 No			ER/Outpatier			4 10 140		me 5□Res			(Specify	')	
ion o	After	ation:	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation		Year)	28b. Time o Injury	M M	28c. Injun Worl 1 🗀	/at k? Yes 2□		28d. Describe	how injur	y occurred			
Division	Hospital or Attend Lat hours after death Funerel Director: / etely filled in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At h (Specif	ome, farm, sti	reet, factor	y, office	2		28f. Location City or To			or Rura	Route Number,	
	e Hospital or At 24 hours after of e Funerel Direct letely filled in by	edical		ysician: To the best of niner: On the basis of and manner stat	examina											
	To the within 2 To the complet	Me	29b. Signature and title of pertiner	-			29	c. Licens	e number			29d. Dat	e signed (/	Month, I	Day, Year)	
	.1/) Jas				D	2865	6			Marc	h 30,	20	04	
	4		30. Name and address merson who Ravi Passi, M.D.					ite 2	208, F	Rockv	ville,	Mary:	Land	2085	50	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 0 2 20	32. Registra	r's Signa	-		aks				<u>-</u> -				

Registrar
DHMH 17 Rev 1/2001

Johns

			1 - For State Registrar	State of Marylan	d / Depa	artment of He rtificate of D	ealth an Death	nd Mental Hyg	giene Reg. No.	2004	123	303
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month March	ath Day 27	2004	3. Time of D	
	/Medic	al	Hilda Mills 1 4a. Facility Name (If not institution, give st	Keene		4b. City, Town, or L	ocation of C			2004 County of Oeath	6:57 a	1. M
	Examin	er	1143 Taylors Islan			Madis				orchest	er	
	Funeral Director		5. Social Security Number 6. Sex 213–16–8281 1□	7. Age (In yrs. 82	last birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of Birth (Month, Day Feb. 1	h y, Year) , 192	9. Birthp Cour 22 Mar	lace (State or itry) yland	Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				1	0d. Inside City	/ Limits
7	Maryl I sho	to	MD Dorchest	er		Madi	.son				1 ☐ Yes 2	2 N 0
ζ	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cour	itry?	
7	ath w		1143 Taylors Is		6 140		21648	2/2/		S.A.	an Indian	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. At them 21s and Ked other than "natural", or items 23s or 28s-1 show or other traumatic event, the Medical Examinar must be notified at or other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		was Decedent of His If Yes, specify Cuban	Specify:	? (Specify Yes or No- Puerto Rican, etc.)	!	4. Race - Americ Black, White, Specify: W		
3-003e	72 hou		15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usual Occupat kind of work done du	tion	f working	16b. Kind	d of Business/In	dustry	
Ž	Aithin 7.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	-	, working		b	-: 4-7	
7	filed within Hygiene. Ither than "		17. Father's Name (First, Middle, Last)			food se		Name (First, Middle,		ate hos	pitai	
Ē	id be ental ked o ic eve	To Be	Elmer K. Mills					Lavelle Pr				
ary	should and Men s marke tumatic	-	19a. Informant's Name/Relationship (Typ	ne, Print)	19b. Mailir	ng Address (Street ar	nd Number o	or Rural Route Numbe	r, City or	Town, State, Zip	Code)	
2	and 2 ealth a ealth a n 27 is		Elmer D. Mills	brother			n Rd.	Bishops 1			1672	
<u>o</u>	ges 1 it of H if itel or oth		20a. Method of Disposition 1 ★Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	emetery, crei	sition (Name of matory or other place,		Date		ation - City or To		
аппо	t. Pa ntmer rtant:		 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 			ty Church		3/30/04 Thomas Fur	Chur	ch Cree	k, MD	
n D	Departing any ir		Brink But	·				Cambridge		21613	•A•	
g.	- 1		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one		h. Do not ent	er the mode of dying,	, such as ca	rdiac or respiratory an	rest,		Approximate Interval Between	een
	Physician		Immediate Cause (Final disease or condition	CONGRET	IVIE	HEARI	- FA	HLURI=			Onset and De	eath L
	/Medical Examiner		resulting in death)	Oue to (or as a conseq							,	T. and
		P.	Sequentially list conditions, b.	Due to (or as a conseq	TIAT						the y	ell
	uted d ansit	Examin	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							,		
ĵ	a exec		resulting in death) Last	Due to (or as a conseq	uence of):							
0/8	cate be executed by sician and the burial-transit	licai	d.	,								
õ ×	leath certificate be executed attending physician and I for use as the burial-transit	/Mec	IF FEMALE:	3c. If yes, outcome of pregna	ancv			-	0.00	ad Ocean of deliver		
C. Box	death e atter	Physician/Med	23b. Was decedent pregnant in the past 12-months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)			23	d. Oate of delive Month		9ar
ٽِ ت	s that the ned by th e detache	by Ph	Part II. Other significant conditions conf	tributing to death but not res	ulting in the u	nderlying cause giver	n in Part I.	23e. Did to	bacco use	e contribute lo th	e cause of dea	ath?
ras	requires sen sign hould be							1 🗆 Y	'es .2.6	No 3□ Prob	ably 4 □Un	iknown
ecora	a s s	Completed						24a. Was autop	sy	24b. Were auto	psy findings av	vailable use of
r =	T e si	Con						perfor	2 A No	death? 1 ☐ Yes	2 🗆 No	
VII	Physicien: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	FD/0	Other		Death (Check only or				(23.1)
0	g Physer this eral di	H .	27. Manner of Oeath	28a. Date of Injury	28b. Time o	f 28c, Injury	at Nursi	ng Home 5 Resid			()	
IVISION	Attending Indeath. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work? M 1 □ Yo	es 2 No					
N N	o it to	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of	ome, farm, str y)	reet, factory, office		28f. Location (S City or Tow		Number or Rura	l Route Numbe	er,
	Hos Pru 4 Pely	edical	29a. Certifier (Check only one) 124 Certifying Physical Exemination (Check only one)	ician: To the best of my knower: On the basis of examina and manner stated.	owledge, deat ition and/or in	h occurred at the time vestigation, in my opi	e, date and p inion, death	place, and due to the coccurred at the time, o	cause(s) a date and p	nd manner as si place, and due to	ated. the cause(s)	
	To the within 2 To the complet	M	29b. Signature and title of certifier			29c. License	number	:	29d. Date	signed (Month,	Day, Year)	
			Muiloter	attender 1	Mysica	Ji. D1.	5541		3/2	29/04	•	
			30. Name and address of person who con Vinodrai Mehta			t., Cambri	പ്രവ	MD 21613	r			
Service Control	Sta	ate	31. Date filed (Month, Day, Year)	32. Registar's Signa		A. N.	-ugc,	21013				

			1 - For State of Maryland / Department Certifit Certifit	ment of Health and Micate of Death	Reg. No	0001
_	Phys /Me	ician dical	1. Decedent's Name (First, Middle, Last) Shirley R. Kingsley		2 Date of Death Month Da	y Year 4. 25 P M
	,	niner	4a. Facility Name (If not institution, give street and number) Doctor's Community Hospital	City, Town, or Location of Death Lanham		County of Death Prince George's
	Funer Directe			Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, Year) 12–6–1915	
	aryland show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
Kingsky	death with the Maryland ms 23e or 28e-f show	Directo	Maryland Prince George's Mitchel 100. Street and Number 10450 Lottsford Rd.	lville Of. Zip Code 20721	10g. Ci	tizen of What Country?
Kin	ie te	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent Ever in U.S. 13. Was If Yes	Decedent of Hispanic Origin? (Spe s, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
8	Maryland 21215-0036 d 2 should be filed within 72 hours aff in and Manalel Hyglens in 171s marked other then "naturel; or treumatic event. The Madical Examitrements over the madical Exam	þ	3 Widowed 4 Divorced Year or Dates: 15 Decedent's Education 16a Decedent's	Yes 2 No Specify: s Usual Occupation	16b. K	Specify: White (ind of Business/Industry
strum	21215 ad within 7 /giene. er then "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 4 years Home	of work done during most of working to see retired) emaker		Home
Rodl	yland yland build be file Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) Victor Nelson Roadstrum		Louise Th	ompson
	and 2 sho ealth and n 27 Is m		Rolfe Kingsley/ Husband 10450 1	ddress (Street and Number or Rura Lottsford Rd., M	Mitchellvil	le, MD 20721
hirley	Baltimore Dermit. Pages 1:8 Department of He mportent: If Iten my injury or oth		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition cemetery, cremator Kalas Crem	ry or other place)		ocation - City or Town, State Agewater, MD
54	Balt permit. Departi	once			_	llas Funeral Home pewater, MD 21037
	Centificate be executed ding physician and itse as the burial-transit	ical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	a mode of dying, such as cardiac o	Dulum	Approximate Interval Between Onset and Death 3 day 30 ylass
		Physician/Med		opic pregnancy ner (specify)		23d. Date of delivery Month Day Year
		b	Part II. Other significant conditions contributing to death but not resulting in the under	ying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
	The The page	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
	of Vita Physicien: this certific ral director,	To Be (25. Was case referred to medical examiner? 1 Yes	26. Place of Death	n (Check only one) me 5 ☐ Residence	6 □Other (Specify)
	Division of Vital Records, To the Hospitel or Attending Physicien: The law requires t within 24 hours after death. To the Funeral Director. After this certificate has been signe complately filled in by the funeral director, page 2 should be	Certification:	27. Manner of Death Matural 5 Pending Injury 28a. Date of Injury 28b. Time	Work? M 1 Yes 2 No	28d. Describe how inju 28f. Location (Street ar City or Town, State	nd Number or Rural Route Number.
	Hospitel of the hours af Funerel Diely filled in	edical Cer	29a. Certifier (Check only (Ch	curred at the time, date and place, a gation, in my opinion, death occurre	and due to the cause(s ed at the time, date and) and manner as stated. d place, and due to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier R. Dellie C. M. D.	29c. License number D0026492	1	te signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print Riad Da Rheel M-D 4000 Mit Cher	elville Rd.	Bowie,	MD20716
	*	State istrar	31. Date filed (Month, Day, Year) APR 0 6 2004 32. Philistrar's Signature	inds.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Mar. **Physician** 30° Joseph Korzeniewski, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 540 St. Martins Lane Severna Park If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** 1⊠M 2□F Days Hours PA Dec. 8,1916 195-10-6660 Director 87 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show Severna Park MD Anne Arundel 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21146 USA 540 St. Martins Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, and Mental Hygiene. Is marked other than "natural", or Items aumatic event, the Medical Examiner m 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 IIWW 1 ☐ Yes 2 X No Specify: 2 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Painter 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 27 Is marked or traumatic even Joseph Korzeniewski Mary Nafrierowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trat. 2005e. Joseph G. Korzeniewski/Son 8318 Fitt Court, Lorton, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Apr. 3, 1 Burial 2 XCremation 3 Removal from State Metro Crematory Baltimore, MD 4 □ Donation 5 □ Other (Specify) 2004 21. Signature (Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 21146 495 Gov. Ritchie Hwy, Severna Park, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SCASE disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): the attending physician a hed for use as the burial-P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 Tyes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No To the nuaprocame within 24 hours after death.

To the Funeral Director: After this certific: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner?
Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Main er of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2. Amedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed au of death (Item 23a) (Type, Print) VONES, MD Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		1- State of Maryland / De State of Maryland / De	epartment of Health and Note of Certificate of Death	Mental Hygiei	
Physic	ian	Decedent's Name (First, Middle, Last)			Day Year 3. Time of Death
/Med Exami	ical	EMMA M. KAMPS 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	APRIL 4	2004 9:00 P ^M 4c. County of Death
Exami	nei	HOMEWOOD HEALTH CARE	FREDERICK		FREDERICK
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Davs Hours Min.	8. Date of Birth (Month, Day, Ye DEC 27 1	9. Birthplace (State or Foreign Country) 9.1 1 NY
		Usual Residence of Decedent		DEC 27 I	
larylan show	5	10a. State 10b. County 10c. City, Town of MD FREDERICK FREDER			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
the Mirra	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
ith with 23a or ust be	a D	7407 WILLOW ROAD	21702		USA
er deal	Funeral		 Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puert 	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
ੂਰ ਛੋ	Þ	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: WHITE
72 hours "natural",	eted	(Specify only highest grade completed) (C	ecedent's Usual Occupation Give kind of work done during most of wor	king 16b	Kind of Business/Industry
ges 1 and 2 should be filed within 72 hr to Health and Mental Hygiene. If itam 27 is marked other than "natur or other traumatic event, Ite Mausal	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	fe. DO NOT use retired) ACHER	E	CDUCATION
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, It a Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Men	Be C	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	
should be nd Mental marked o	2	THOMAS KELTY		EINE MCDC	
MG 2 stritth and 27 Is n	1	BOR WOTCTECHOWSKI SON-IN	Mailing Address (Street and Number or Ru	ESVILLE.	
itam 2		20a. Method of Disposition 20b. Place of D	BOX 349 BARNE isposition (Name of crematory or other place)		. Location - City or Town, State
Pages 1 ment of Hitar tant: If itar	1	The state of the s	TOIL OILDINIT.	5/04 FR	EDERICK, MD
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service Licerisee	22. Name and Address of Facility HILTON FUNERAL P.O. BOX 86, BA	HOME ARNESVILL	E. MD 20838
		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Opset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of)	olitinative Pul	monary)	Bunce Yenis
Examiner				(
be is	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
cate be executed bhysicien and the burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of)			
cate be cate by the solution of the buri	dicail	d			
entifica ding ph	Med	IF FEMALE: 23c. If yes, outcome of pregnancy			201 But of the
The law requires that the death certificate are has been signed by the attending physpage 2 should be detached for use as the	hysician/Med	23b. was decedent pregnant in the past 12 months? 1 Use birth 2 Fetal death 1 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
at the c by the	Physi	9 ☐ Unknown			
ires thi	þ	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 □ No 3 □ Probably 4 □ Unknown
w requ	Completed	Note on week States		24a. Was an	24b. Were autopsy findings available
The la	dwo	Decoration		autopsy performed 1 ☐ Yes 2 🕱	prior to completion of cause of death? No 1 ☐ Yes 2 ☐ No
clan: ertifica ector, p	BeC	25. Was case referred to medical examiner?		th (Check only one)	
Physi rthis o	5	1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outp 27. Man 1 Death 28a. Date of Injury 28b. Tin	ne of 28c, Injury at	ome 5 Residence	e 6 □Other (Specify) njury occurred
nding ath. r: Afte e fune	ation	atural 5 ☐ Pending (Month, Day Year) Inju	ıry Work? M 1 ☐ Yes 2 ☐ No		
or Atta after dea Diracto	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/one) and marker stated.			
To the within To the comple	₩.	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
		Lary Pilling	1) D16450		715/04
15		30. Name an address of person who completed cause of death (16.1.20a) (Ty CASPER / E. CLINE, III 300 W.	ype, Print) 9th STREET, FREI	DERICK. N	4D 21701
S Regis	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	& Sports	, -	
riegis	AT CIT	APR 0 8 2004 Serens	7-1-1-1		

			Registrar C6	partment of Health and Mental Fertificate of Death	lygiene Reg. No. 2004 1230
10	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) Joseph Sewell Kennedy 4a. Facility Name (If not institution, give street and number)	2. Date of Month April 4b. City, Town, or Location of Death	Death Day Year 4 2004 7:10 P M 4c. County of Death
	Funeral Director		Northampton Manor Nursing Home 5. Social Security Number 6. Sex 1 M 2 D.F 84 Yrs.	Months Days Hours Min. (Month,	Birth Pay, Year) 9. Birthplace (State or Foreign Country) 9. 1020
	D	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	_ocation	8, 1920 Mary Limits 10d. Inside City Limits 150 Yes 2 \(\text{No} \) No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depardment of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f ahow any injury or other traumatic event. I'm Medical Exarting traine to itemitied at once.	Funeral Director	10e. Street and Number 1001 Carroll Parkway 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	10f. Zip Code - 21701	10g. Citizen of What Country? United States No- 14. Race - American Indian, Black, White, etc.
Maryland 21215-0036	hin 72 hours afl a. In "natural", or Medical Eran	Completed by F	(Specify only highest grade completed) (Giv.	1 ☐ Yes 2 ☑ No Specify: edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	Specify: White 16b. Kind of Business/Industry
/land 21	ould be filed wit Mental Hygiene arked other tha atic event, the	To Be Com		erator Engineer 18. Mother's Name (First, Midde Anna Poole Con	,
	es 1 and 2 should of Health and Men fitem 27 Is marke r other traumatic.	•	Ellen May Burke Kennedy / Wife 1001- 20a. Method of Disposition 20b. Place of Disp	ing Address (Street and Number or Rural Route Num Carroll Parkway Freder Date Dottion (Name of particle)	nber, City or Town, State, Zip Code) ick, Maryland 21701 20c. Location - City or Town, State
Baltimore,	permit. Pages Department of I Important: If it any injury or o		*4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	n Crematory April 2004	Frederick, Maryland Funeral Homes, P.A.
\$ (\lambda	rnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence):		
8760,	4	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		
P.O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
	equires that sen signed by rould be deta		Part II. Other significant conditions contributing to death but not resulting in the conditions of the	. + .	tobacco use contribute to the cause of death? Yes 2240 3 Probably 4 Unknown
ital Rec		e Completed by	Prod TATE CA - Domnt. 25. Was case referred to medical	24a. Wa aut per 1 Yes	opsy prior to completion of cause of death? 200 No 1 Yes 2 No
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien 27. Manner of Death 1 Valural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury At home, farm, st building, etc. (Specify)	of 28c. Injury at Work? M 1 Yes 2 No Other: A vursing Home 5 Results and Provided	sidence 6 Other (Specify) how injury occurred (Street and Number or Rural Route Number.
ā	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical Cert	29a. Certifier (Check only one) Westifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and due to the	e cause(s) and manner as stated. date and place, and due to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier Country Drone J.	29c. License number	29d. Date signed (Month, Day, Year)
	Sta Registr	100	30. Name and address of person who completed cause of death (Ibom 23a) (Type, Austin A. Pearre, Jr, M.D. 30 W. I 31. Date filed (Month, Day, Year) 32. Registrar's Signature	•	Maryland 21702

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment o			-	- ^ ^	04 12308
	Physici	an	1. Decedent's Name (First, Middle, Last					-	2. Date of De Month	_	3. Time of Death 004 0430 M
	/Medic	cal	Doris Lake Kleinf 4a. Fecility Name (If not institution, give			4h City To	um orlo	cation of Death	March	4c. County of	
	Examin	ier	1714 Doe Drive	street and number)		1	nksb				rroll
	Funeral		5. Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Y	rear I	Under 24 Hrs.	8. Date of Bir	h	Birthplace (State or Foreign Country)
	Director		243-46-0160]M 2 ⊠ F	72 Yrs.	Months D	ays	Hours Min.	Jan	28 1932	NJ
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Le	ocation					10d. Inside City Limits
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	72 hours after death with the Maryland natural', or thams 23a or 28a-f show Alcel Examination in Colling and	Director	10e. Street and Number			10f. Zip Co	ode			10g. Citizen of W	hat Country?
	th wit	aiD	1714 Doe Drive			2	1048			USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 N	ver in U.S. 13.	Was Decedent If Yes, specify	t of Hispa Cuban, I	anic Origin? (Sp Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race Black	- American Indian, , White, etc.
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ₹ N If Yes, Give Year or Dates:	0	1 ☐ Yes 2	No S	Specify:		Specify:	White
21215-0036	2 hour		15. Decedent's Edu	cation	16a. Dece	dent's Usual O	ccupatio	n		16b. Kind of Bus	
215	within 7; iene. than 'n	pje	(Specify only highest grad Elementary/Secondary (0-12)		life.	DO NOT use n	etired)	ng most of worl			
7	filed wit Hygiene Sther the	Completed		College (1-4or 5-	Tech	nical		strator		Art	
Maryland	should be filed withir and Mental Hygiene. marked other than imatic event, I a Ma	Be	17. Father's Name (First, Middle, Last)				18			Maiden Sumame)
Z Z	should nd Men marke umatic	ဥ	George Faley 19a. Informant's Name/Relationship (T)	na Print)	10h Maiti	na Address (Si	troot and	Geneva		r, City or Town, S	Note Tin Code)
Ma	od 2 sho lth and 27 is m		Karen Roehrle/daug						urg, MD	21048	itate, Zip Code)
re,	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Itam 27 Is marked other than "natural", or Itams 23a or 28a-1 show or other traumatic event, Ita Medical Examinational Lancollies.		20a. Method of Disposition		20b. Place of Dispo cemetery, cre	sition (Name	of		72004	20c. Location - C	City or Town, State
E	Pages nent of int: if it try or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Carroll C	-		1 1	/2004	Hampste	ead, MD
Baltimore,	permit. Pages Department of I Important: If Its any injury or o		21. Signature of Funeral Service Licens	98	Ë	ritts 1	fune hina	ral Hom	e and Cl	napel, P. minster,	.A.
	50.00		23a. Pert1. Enter the disease, or compl shock, or heart failure. List only o	cations that caused	the death. Do not ent						Approximate fnterval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Coro	consequence of):	ry Di	Sca	LL			Onset and Death
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	D #	iner	Sequentially list conditions, if any, leading to immediate cause, Enter Underlying Cause (Disease or injury	Due to (or as a	sequence of):						
	ecute and I-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of);						
8760,	icate be executed physician and s the burial-transit				33/133433/133 3/7.						1
687	ficate p phys	edic		l							
Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death 3	Ectopic pregn Other <i>(specif</i>				23d. Date Mont	,
P.0	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions con	tribuling to death but	not resulting in the u	nderlying caus	e given i	n Part f.	23e. Did to	bacco use contrib	oute to the cause of death?
rds	w requires been sign should be	q pa	Hy perter	W(FM					1 2 Y	es 2□No 3	☐ Probably 4 ☐ Unknown
Vital Records,	aw re	Completed	peupher	of more	en durie	and.			24a. Was		ere autopsy findings available
Ä	0 4 9	mo		0.0-0.0-	L. Ugira				autop perfor 1 ☐ Yes	med? / de	or to completion of cause of ath? ☐Yes 2☐ No
ita	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?				26	. Place of Deat	h Check on o		
of \	Physic this c	P	1 ☐ Yes 2 → Yo	lospital: 1 Inpatien				-		ence 6 Other	
no On	ding F	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury		Injury at Work?	2 🗆 No	28d. Describe h	ow injury occurred	
Division	Attending Physician: r death. ector: After this certification: by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injur	y - At home, farm, str				28f. Location /S	treet and Number	or Rural Route Number,
<u>S</u>	after after Dire d in b	erti	4 ☐ Homicide determined	building, etc.	(Specify)				City or Tow	n, State)	or trong trong trained,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying Physical Check only 2 Medical Examione)	tician: To the best of ner: On the basis of and manner state	my knowledge, death	n occurred at the	he time, o my opinio	date and place, on, death occur	and due to the o	ause(s) and mann late and place, an	ner as stated. d due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier)	/		cense nu				Month, Day, Year)
)				1	\/	0	002	50760	,	3/29/	4
	WSV 15		30. Name and address of person who co	mpleted cause of de	ath (Wen 23a) (Type,	Print)			wastmi	1	0
-	()		ERNESTO MO	voore i	Ned 680	e po	ole	RO	wastm.	nster 1	nd 20157
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			For State Registrar	State of Maryland		tment of H		lental Hygier	_ 711111	12309
(3	I de la		Decedent's Name (First, Middle, Last)					2. Date of Death Month 3	Dey 28 Year	3. Time of Death
	Physicia /Medic	et	SYLVIA	KING					1009	14:01 M
30	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or TAXOMA	PAK		4c. County of Death MONTGOME	RY
913			5. Social Security Number 6. Sex	HESPITAC 7. Age (In yrs. la:	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Dete of Birth		elece (State or Foreign
	Funeral Director			M 201 6	8 Yrs.	Months Days	Hours Min.	Aug 1st, 19	35 V/r	GINIA
	D .		Usuel Residence of Decedent 10a. State 10b. County	10c City	Town or Loca	ation				0d. Inside City Limits
	Aaryla f sho	ō	mn 86	BR	enti					1 Ves 2 No
	n the Maryland r 28a-f show rotilied at	rect	10e. Street and Number	# 114		10f. Zip Code	46.0	10g.	Citizen of What Cou	ntry?
	23a or	ai D	4500 38 Plac	e#114		20	122		USA	
	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. A chief than "natural", or items 23s or 28s-f show do ther than "natural", or items 23s or 28s-f show event, the Medical Examinar must be notified	Funeral Director	11, Waltai Olales	2. Was Decedent Ever in U.S Armed Forces?	. 13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	irs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		Specify: Blo	ick
5-0036	2 hou	ted	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Decede	ent's Usual Occupa	ation during most of work		. Kind of Business/In	dustry
21	ithin 7	Completed	Elementary/Secondary (0-12)	Cotlege (1-40r 5+)	life. D	O NOT use retired	, ,		1 . + 1	Paras
2	filed with Hygiene. ther thai	CO	17. Father's Name (First, Middle, Last)	- J.	CONSE	2 R Vai IV	e Operation	e (First, Middle, Maid	des pitAL	- NACDIOS
and	S d is D	To Be	ρ ρ	re			FRAN		ANKS	
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	and 2 ealth m 27 i		Robertia, King (H		4500			Brentwoo		
altimore,	Pages 1 nent of H ant: If Itee ary or oth		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ R			ition (Name of atory or other place		_	Location - City or To	
Ħ	permit. Page Department of Important: If any injury or once.		* 4 □ Donation 5 □ Other (Specify) 21. Signature/of Funeral Service License		URREC	HON Cer	n . 1913	-State	ALSILNO	ID.
Ba	Depa Impo any i		Siene 4/1		91			NW, Wasi		
			27a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death.	Do not ente	r the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate Interval Between
2	Physician		Immediate Cause (Final disease or condition		PINEL M.	ME				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque		. AATVALL	DISEASE		=======================================	
		9.	Sequentially list conditions,	Due to (or as a conseque	Circum?	4 FILIERY	1/1)[-16]-6			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
0,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequent	ence of):					
	icate be executed physician and s the burial-transit	dicai		J						
9 X	eath certific attending p	/Wed	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregnan					23d. Date of deliv	ery
Box	death e atter d for u	Physician/M	in the past 12 months?	1 Live birth 2 Fetal		Ectopic pregnancy Other (specify)			Month	Day Year
0	at the de by the a stached t	hys	9 Unknown	9L Unknown				I an Didustry		ha assas of death?
	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	þ	Part II. Other significant conditions con	tributing to death but not resul	lting in the un	derlying cause giv	en in Part I.	1 Yes	co use contribute to t 2 □ No 3 □ Prol	ne cause or death? cably 4 ⊟Unknown
orc	w requir been s should	eted						24a. Was an		opsy findings available
Records,	he law s has l	Completed						autopsy	prior to co	mpletion of cause of
		a	25. Was case referred to medical				26. Place of Deal	1 ☐ Yes 2, ☑ h (Check only one)	No 1 ☐ Yes	2L NO
of Vital	Physician: r this certific ral director,	To B	examiner? 1 Tes 2 No	lospital: 1 ☐ Inpatient	ER/Outpatient	3□ DOA Dth	er: 4 Nursing Ho	me 5 Residence	6 ☐Other (Speci	(y)
0 0			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1	yat k? Yes 2 □ No	28d. Describe how i	njury occurred	
Division	ten leat tor: the	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hos	me, farm, stre		163 2 100		t and Number or Run	al Route Number,
<u>></u>	after I Dire	Certification;	4 Homicide determined	building, etc. (Specify,				City or Town, S	ta te)	
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edical C		sician: To the best of my knowner: On the basis of examinati						
	To the within 2 To the comple	Med	29b. Signature and title of certifier			29c. Licens	e number	29d.	Date signed (Month,	Day, Year)
			Inf ! History	MO		\mathcal{D}	48083	70	larch 28,	2004
6	-(2)		30. Name and address of person who co	mpleted cause of death (Item 9210 Page-	23a) (Type, F	Print) Blud S.	La 212 1	29d. 7a Rockville	Md. 208	50
	St	ate	31. Date filed (Month, Day, Year)	37 Registrar's Signat	ure	siva · M	ere our	40100	7.00	_
14.5	Regist		APR 0 2 2004	Eller 1	100	the s				

N			For State	State of M	larylan		artment of H			•	_	0001	12210
			Registrar 1. Decedent's Name (First, Middle, Li	ast)		Cel	uncate or i	Jeaur		2. Date of De	Reg. No.	2004	3. Time of Death
Н	Physici		Harold Leon Kee	•						Month March	23.		2329 P ^M
*	/Medic Examin		4a. Fecility Name (If not institution, gi	ve street and number,)		4b. City, Town, or	Location of	of Death			County of Death	
			Prince George's				Cheve	-4				Prince G	
	Funeral			Sex 7. Ag 1⊠M 2□F	ge (In yrs. 57	last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 6/2/1	h y, Year)	9. Birth	place (State or Foreign intry)
	Director		420-60-9961 Usual Residence of Decedent		J /	113.				6/2/1	946	ALA	báma
	yland how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	e Mai	ctor	MD Prince	George's		Uppe	r Marlbo	ro					1X Yes 2 ☐ No
	vith th	Director	10e. Street and Number	11 D1			10f. Zip Code	2077/			-	zen of What Cou	
	eath v	erai	12313 Ronald Bea	12. Was Decedent	Ever in 11	S 12.1		20774				ed Stat	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene Important: If item 27 is marked other than "natural", or Iteme 23a or 28a-f show appringing or other traumatic event, the Medical Exam. In trivial terrolling at Once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces' 1 Yes 2 X If Yes, Give Year or Dates:	?		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☎ No	Specify:		Rican, etc.)		Black, White	, etc.
2-0	72 ho	Completed	15. Decedent's E	ducation		16a. Dece	dent's Usual Occupa	ation	t of worki	na	16b. Kir	nd of Business/l	ndustry
2	han han	mple	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retired)	. 01 *******	·9	P	rivate	
2	iled w Tygier thar ti		12th 17. Father's Name (First, Middle, Las	r)			Electricia		r'e Name	(First, Middle,	Maiden	Sumamal	
and	d be f	o Be	Lesley Keener	,					ie	(First, Middle,	Johr	,	
7	shoul nd Me mark	To	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	ng Address (Street a			l Route Numbe			p Code)
ž	and 2 alth a 27 is		Frances Keener/	Wife		12313	Ronald 1	Beall	Rd.	Upper	Mar	lboro,	MD 20774
ore,	of He of He fitem r oth		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3 [Bemoval from State	1 6	lace of Dispo	sition (Name of natory or other plac	- 1		ate		cation - City or T	
Ē	Pag ment tant: f		*4 □Donation 5 □ Other (Spec	ify)	Res		ion Ceme	-				iton, MD	
Ball	Departimon Important in Succession		21. Signature of Funeral Service Lice	nsee			. Name and Addres		-				
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	aplications that cause	d the deati								Approximate
	Physician		Immediate Cause (Final	one cause on each I	ine.		uries						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as	a conseq								
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8760,	icate be executed physician and s the burial-transit	dicai E		d									
9	tificating phy as the	ledk					andi-)			SVV = = Sinin === s C
Вох	death certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy				2	3d. Date of deliv	•
О. Ш	the at	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown	4□Pregnant a 9□ Unknown			Other (specify)					Month	Day Year
P.0.	that the de ned by the a detached t	Phy	Part II. Other significant conditions	contributing to death I	out not resi	ulting in the ur	nderlying cause give	n in Part I		23e Did to	hacco us	se contribute to t	he cause of death?
Division of Vital Records,	o de de s	d by	•							1 🗆 Y		No 3□Pro	
CO	aw requir as been si 2 should	Completed								24a. Was a		24b. Were auto	opsy findings available
Ä	The lav ate has page 2	mo							+++	autop. perfor 100 Yes		prior to co death? 1 A Yes	impletion of cause of
ita	clan: Brtifles	Be	25. Was case referred to medical examiner?					26. Place	of Death	Check only or		A	
7	Physician: r this certific ral director,	P	1 X Yes 2 □ No	Hospital: 1 Inpati		ER/Outpatien		4 1140				Other (Special	(y)
on C	tending Physician: The leath, tor: After this certificate hathe funeral director, page	Certification:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inju	y Year)	28b. Time of Injury	28c. Injury Work	at ? ∕es 2.1Ω1	17	8d. Describe h	F a 2	notion Ve	hiclenhich
Sic	or Attending after death, Director: After in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not to determined	00 Dlace of la		20:05	et, factory, office	63 2 [2]	E	8f. ocation (S	treet and	Number or Buc	al Boute Number
<u>S</u>	after after Direct	erti	4 Homicide	building, e	tc. (Specify	1)	Road			City or Tow	n, State)	RT 202 (2 Technology
	To the Hospital or At within 24 hours after d To the Funaral Direct completely filled in by	edical C	29a. Certifier 1 ☐ Certifying P (Check only 2 ☑ Medical Exa	hysician: To the best miner: On the basis of	of my kno	wiedge, death	occurred at the tim	e, date and	d place, a	nd due to the o	ause(s) a	and manner as s	itated,
	To the H within 24 To the F complete	Medi	one) 29b. Signature and title of certifier	and manner st	ated.		29c. License						
	wil To			. m.D				190111081		2		signed (Month,	
	1		30. Name and address of person who		death (Item	23a) (Type	OCME Print)				Marc	ch 24, 2	2004
1950	6		LING LI.		2 (11011		.11 Penn S	Stree	t, Ba	altimor	e, Ma	aryland	21201
(%)	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 9 2004	32. Registi	rar's Signa	ture _							

		•	For State Registrar	State of M	laryland / De	partment e <i>rtificate</i>					iene .g. No. 20	n L	12	311
			Hegistrar Decedent's Name (First, Middle)	le, Last)		or imoure	, O, L	- Catiri		2. Date of Deat	h	0 7	3. Time	of Death
	Physicia		Frederick	Jerome K	u11					March	Day 2 5 2	Year 004	6:2	ОАМ
}	/Medic Examin		4a. Facility Name (If not institution	n, give street and number)	4b. City, T	own, or	Location of	of Death		4c. County	of Death	1	
			1732 Stratto	on Road			ofto				Anne	Aru	nde1	
	Funeral		5. Social Security Number	6. Sex 7. A 1	ge (In yrs. last birthda 7 / Yrs.	y) If Under 1 Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day, Nov. 6,	Year)	Cour	trv)	or Foreign
	Director		579-36-8709 Usual Residence of Decedent		74 Yrs.					NOV.O,	1929	was.	h'.,	D.C.
	/land		10a. State 10b. County		10c. City, Town or	Location						1	0d. Inside	City Limits
	Man B-1 sh	io	MD Anne	Arundel	Cro	fton							1 X Ye	es 2□No
	or 28)ire	10e. Street and Number			10f. Zip (1	g. Citizen of	What Cour	itry?	
	ath wi	rai	1732 Stratto					21114				S A		
	er deg	nue	11. Marital Status 1 □ Never Married 2 Mar	12. Was Deceden	t Ever in U.S. 1	 Was Deceded If Yes, specified 	ent of His fy Cubar	spanic Orig n, Mexican	gin? (Sp i, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ck, White,		
36	rs aft	by Funerai Director	3 ☐ Widowed 4 ☐ Divorced	11111	1952-54	1☐ Yes 2	∭ No	Specify:			Specif	y: Whi	te	
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28a-f show the Madical Examilian must be motified at			nt's Education	16a. De	cedent's Usual	Occupa	tion	t of work	ina	16b. Kind of B	usiness/Ind	dustry	
215	thin 7	Completed	Elementary/Secondary (0-12)	completed) College (1-4or	5+)	ve kind of work . DO NOT use				1				
2	led w lygier her th		47 Fathada Nama (First Middle	4	E16	ctron				r e (First, Middle, M	Aeros			
Maryland	od of	Be	17. Father's Name (First, Middle, Frederick Co							es Robi		118)		
2	shoulk nd Me mark matik	၉	19a. Informant's Name/Relations		19b. Ma	iling Address ((Street a			al Route Number,		State, Zip	Code)	
Š	nd 2:		Diane E. Kul	1 / spouse	e 173	32 Str	att	on R	d.	Crofto	n. MD	. 21	114	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 le marked other than "naturel; or Items 23e or 28a-1 show entry or other traumatic event, the Madical Examinating the malified at ADGE.		20a. Method of Disposition	2 CD	20b. Place of Dis				Mary Control of Control		20c. Location			
<u>Ĕ</u>	Page nent c ent: If ury or	į	1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (S	Specify)	Metropo				3-2	7-2004	Alexa	ndri	a, V	Α.
alt	epartr porto y inj	i	21. Signature of Funeral Service	License	0/	22. Name and				eall Fu			_	
_	20 E 8 9	9 7	1 660	an vouce						y. Bow		D. 2		
			23a. Part1. Enter the disease, or shock, or heart failure. List		line.	. 1		n 1	4		ıst,		Approximately Interval Bookset and	etween
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a.) \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		oughi	5	lunh	m	a			12-	mer
	Examiner			Due to (or as	s a consequent of):									
		ē	Sequentially list conditions,	b. Due to for a	s a consequence of:									
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00,	te be executed ysician and ne burial-transit		resulting in death) Last	Due to (or as	s a consequence of):									
68760,		dicai		d									-	
9 X	certifi Iding Ise as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom-	e of pregnancy						23d. Da	te of delive	irv	
Вох	death certifica e attending pt id for use as ti	Physician/Med	in the past 12 months?	4☐Pregnant a		B□Ectopic pre B□ Other (spe							Day	Year
P.O.	t the by the tacher	hys	9 Unknown	9□ Unknown										
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ord	requir	ted								1 ☐ Ye	s 2,52(No	3∐ Prob	ably 4 □	JUNKNOWN
Records,	e law has b le 2 st	Completed								24a. Was ar autops perform	/	Were autor prior to cor death?	psy finding npletion of	s available cause of
alF	Thate page									1 ☐ Yes 2	(2k/Vo	1 🗆 Yes	2□ No	
<u>Ş</u>	Phyelcien: r this certific ral director,	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ØNo	Hospital:	ient 2 ☐ ER/Outpat	ient 3 DO4	Otho			n <i>(Check only one</i> me 歩 ≰ Reside		ar (Canaih	4)	-
0	g Phy erthis eral d	n; To	27. Manner of Death	28a. Date of Inj			c. Injury Work		-	28d. Describe ho			,	
ion	Attending ir death. ector: After by the fune	atio	E //doidoin	igation	ay Year) Injur	М		es 2 🗆 l	No					
Division of Vital	or Atte	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Place of it	njury - At home, farm, atc. (Specify)	street, factory,	office			28f. Location (Str City or Town		er or Rura	Route Nu	mber,
Ω	pitel o		29a. Certifier Certifyin	ng Physician: To the bes	t of my francisches de	a4b a a a a a a a a	A Ab - 4'		4 = 1 = 2		(.)			
	To the Hospitel or Attending Phyelcien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical one)	Examiner: On the basis and manner s	of examination and/or	investigation, i	in my opi	inion, deat	th occurr	ed at the time, da	te and place,	and due to	the cause	(s)
	ro the within ro the	Me	29b. Signature and title of certifie	ar Olla		29c.	License	number		29	d. Date signe	d (Month, I	Jay, Year)	
			> Xtto	1/ Well	m	_ 1	0	811	8		March	26,	200	4
1	, Iva		30. Name and address of person	who completed cause of	death (Item 23a) (Typ	e, Print) 900	BES	5560	TE!	20 10	JWW.	mo	2140	,
	Sta		31. Date filed (Month, Day, Year,		trar's Signature									
	Registr	ar	MAR 2 9 20	U4 Deneral	M. Papper	and the second								

State of Maryland / Department of Health and Mental Hygiene 200412312 State
Registra/MEND#23a(b,c)perMD3/30/04,BMW,Mcco Certificate of Death 2. Date of Death 3. Time of Death 5:50 a Decedent's Name (First, Middle, Last) Day Month Year Sadie **Physician** Kalman 26,2004 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Nursing Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 9. Birthplace (State or Foreign **Funeral** 194-10-8922 1 ☐ M 2 💢 F 96 Yrs Feb. 16, 1908 Penna. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show the Medical Examinar fourt be notified at MD Montgomery Rockville 1 Tyes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 Adclare Road filed within 72 hours after death with 20850 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White þ 3 XWidowed 4 □ Divorced ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) 1 2 College (1-4or 5+) other than Seamstress Garment Factories 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked of Pages 1 and 2 should be Anna Maria Scherrer Unknown Horn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Itam 27 is
any injury or other trau Lisa Tweardy/Grandaughter 1 Turnberry Court Moorestown, N.J.08057 20b. Place of Disposition (Name of cemetery, crematory or other place)
Union Cem. Hellertown3/29/04 Hellertown, PA. 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) uneral Service Licens e PHILIP OR RINALDI FUNERAL SERVICE, P.A 21. Signature 9241 Columbia Blvd.Silver Spring, Md20910 Me4 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Aspiration Due to (or as a consequence of): Pneumonia **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attanding Physician: The law requires that the death certificate be executed transit 10(1) and Due to (or as a consequence of) the burial Box 68760 attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Cher (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? been sign 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2 XNo 1 ☐ Yes 2□ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 41 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No ို 1 Inpatient 2 ER/Outpatient 3 DOA To tha Funeral Diractor; After th completely filled in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. s after death 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 33a) (Type, Print) Md Merlyn Vemury 9801 Georgia Ave. Silver Spring 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State MAR 3 0 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 12313 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** March 29, 2004 7:30 PM M James Joseph Kane /Medical 4a. Fecility Name (If not institution, give street and number)
Sligo Creek
Nursing & Rehabilitation Center 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Days Director 071-14-7558 85 New York September 2, 1918 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Exercipation to include any page. 1 ☐ Yes 2 No Directo Maryland Bethesda Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4400 East-West Highway #328 20814 <u>United States</u> Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ø Yes 2 □ No If Yes, Give Year or Dates: WWTT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2K Married 1 ☐ Yes 2 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced WWII White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Research Psychologist Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 James Patrick Kane Esther Ulton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4400 East-West Hi hway #328 Bethesda, Maryland 20814
Loc of Disposition (Name of Date 20c. Location - City or Town, State Marie Kane/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. March 30, 2004 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue M00335 Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee levy 23a. Pert1. Enter the disease, er complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Aspiration Pneumonia resulting in death) /Medical Due to (or as a consequence of): Examiner Alzheimer's Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-transit or Attending Physicien: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) the attending physicien Completed by Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 X No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) c mpletely filled in by 4 Homicide IXI Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records.

31. Date filed (Month, Day, Year) State APR 02 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STRILLIA TES 3-15HAWM/ ST #1 Halthull MD2018= 32. Registrar's Signature

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			1 = For State Registrar	State of M	arylan		artment rtificate					giene Reg. No	200) [,	12:	314
			1. Decedent's Name (First, Middle, Las	st)							2. Date of De	ath Da	v Y	ear	3. Time of	Death
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	Examin		4a. Facility Name (If not institution, give						Location of	of Death		40	. County of	Death		
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	Funeral		5. Social Security Number 6. S 215–44–6364	BX 7. AG	62	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da			Coun		r Foreign
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	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							11	Od. Inside Ci	ity Limits
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21	filed within Hygiene. Ither than "	Sor		5+		Cert	ified	Pub1					ccoun		<u> </u>	
and	be fill	Be	17. Father's Name (First, Middle, Last)								e (First, Middle,					
Maryland 21215-0036	12 should be filled within h and Mental Hygiene. 7 is marked other than "traumatic event, the Mes	1º	Frederick Koe 19a. Informant's Name/Relationship			19b Maili	ng Address	/Street 3			Frances				Cadal	
Ma	d 2 s Ith an 27 ia trau		Joyce Koenemar													MD
ē,	s 1 and f Health item 27 other ti		20a. Method of Disposition	I/ WIIC	20b. P	Place of Dispo emetery, crei	sition (Nan	ne of		100	West, L	20c. L	ocation - Ci	ty or To	wn, State	20395
Ë	Pages nent of Hant of		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify			eensbo	-		. P.	Apri]	2004	Gre	ensho	ro.	Mary1	and
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ia marked other than "natural", or items 23a or 28a-f show among injury or other traumatic event, the Medical Examination and be notified at once.		21. Signature of Puneral Service Licen								Funeral	11	T.		патут	anu
m	Pe De De De De De De De De De De De De De		(unchew S	Cole		50	00 Uni	ver	sity	$^{ m B1vd}_{ m B}$. W., S	ilve	ne Ind er Spi	c. ring	, MD 2	0901
п			23a. Part 1. Enter the disease, or company shock, or heart failure. List only	lications that cause ne cause on each li	d the deat ine.	h. Do not ent	er the mode	of dying	g, such as	cardiac	or respiratory ar	rest,	11 21 32		Approximat Interval Bet	ween
	Physician	0.5	Immediate Cause (Final disease or condition	Merkle										ì	Onset and I Ionths	
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9	rtifica ng ph as th	Physician/Medical	IF FEMALE:		-											
Box	eath certific attending pl	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	of pregna 2 DFeta	incy I death 3 [∃Ectopic pre	egnancy					23d. Date of			rear
.O.	the at	/slcl	1 Yes 2 No	4□Pregnant a 9□ Unknown	t time of d	eath 5	Other (spe	ecify)					141011(1)		buy	Out
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Vital		a	25. Was case referred to medical						26. Place	of Deatl	1 ☐ Yes	2 🔯 No ne)	1	Yes	2 NO	
<u>></u>	S 0 -	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 Inpati	ent 2 🗌	ER/Outpatier	nt 3□ DQ	A Othe			me 5 Resid		6 🖾 Other	(Specify	Hospi	ce
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Sio	Attending r death.	catle	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2 □ I							
Division	or Att	Certification:	4 Homicide determined	28e. Place of In building, e	jury - At ho tc. <i>(Specif</i>	ome, farm, sti y)	reet, factory	, office			28f. Location (S City or Tow			or Rural	Route Num	ber,
	pital ours a eral (29a. Certifier 1⊠ Certifying Ph	ysicien: To the best	of my kno	wledge deat	h occurred a	at the tim	ne date an	d place	and due to the	ralleo/e	and mann	er as st	ated	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical		niner: On the basis of and manner st	of examina)
	To the Within To the	Me	29b. Signature and title of certifier				29c	. License	number	-		29d. Da	te signed (/	Month, L	Day, Year)	
	15		I Chile hy	rynel-	,			D	42452			Ma	rch 31	1, 2	004	
•	1-		30. Name and address of person who	completed cause of	death (Item	n 23a) (Type,	Print)									
			Chitra Rajagopal		1811	ll Pri	nce Ph	nili	Dri	ve,	#327,	01ne	ey, MI	20	832	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 0 2 200	32. Regist	rar's Signa	J.	Spa	eks	/							
			L1 1/ 0 14 1201			6	1 1									

CHARLES KOENEMAN

			1 - For State Registrar		f Maryland	d / Depa <i>Cei</i>	artment of F rtificate of	lealth an <i>Death</i>	d Mental Hy	Reg. No	2004	12315
	Physici /Medio		Decedent's Name (First, Middle ROSE		OENIG				2. Date of De Month MARCI	Da		3. Time of Death 5:35 P M
	Examin		4a. Facility Name (If not institution				4b. City, Town, o		eath		. County of Death	•
			ARDEN COURT ASS 5. Social Security Number		TNG 7. Age (In yrs. la	et hirthday)	POTOMA If Under 1 Year		Hrs. 8. Date of Bi		1ONTGOME	RY uplace (State or Foreign
	Funeral Director		030-12-8352	1 □ M 2 💢 F	92	Yrs.	Months Days		Min. (Month, D.) April	av. Year)	Cou	sachusetts
	ט		Usual Residence of Decedent						125-			
	within 72 hours after death with the Maryland ene. than "naturei", or items 23e or 28e-f show se Medical Exer: it er mant to or ceilled at	<u>_</u>	10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	he M	ecto	Maryland Montg	omery	Poto	omac	104 7in Code			10m Cit	inna of What Cou	
	a or 2						10f. Zip Code	,		-	izen of What Cou	TO SECURE
	ns 23	Funeral Director	10718 Potomac T	12. Was Dece	dent Ever in U.S	3. 13.	2085 Was Decedent of F		? (Specify Yes or No ruerto Rican, etc.)		ted Stat	ican Indian,
9	after or iter	Fur	1 Never Married 2 Marri	Armed Fo	2 X No	-	fYes, specify Cub 1 □ Yes 2 🛣 No		uerto Rican, etc.)		Black, White	, etc.
21215-0036	urai', c	d by	3√ Widowed 4 □ Divorced	If Yes, Giv Year or D	ates:		1 1 1	эреспу.			Specify: W	hite
5-	"natu	Completed	15. Decedent (Specify only highes			(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of	working	16b. K	ind of Business/I	ndustry
2	withir ene. than	Jmc	Elementary/Secondary (0-12)	College (1	-4or 5+)		al Hygie			De	ntistry	
0	Hygi other ent, 1	Be Co	17. Father's Name (First, Middle,			Dene	<u>ur 11, 810</u>	T	Name (First, Middle			
lar	uld be Menta irked itic ev	To B	Joseph Boor	ky				Rebec	ca	Le	vine	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any righty of other traumatic event, the Medical Exercitive from the notified at ance.	·	19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailir	ng Address (Street	and Number o	r Rural Route Numb	er, City o	or Town, State, Zi	ip Code)
≥,	and lealth m 27 her tr		Robert Koenig,	Son	20h Bis		2	-	Bethesda,			0.11
lore	It of It		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		State		sition (Name of natory or other pla				ocation - City or T	
Baltimore,	it. Pa		'4 □ Donation 5 □ Other (S) 21. Signature of F neral Se, see I	-	B'N		ith Cemet	Committee of the Commit	the second secon			Massachuset
Ba	perm Depa impo any i		21. Signature of Thire and Service in	九十					erg Memori			Inc. 20852
			23a. Part1. Enter the disease or shock, or heart failure. List	complications that of	aused the death.				Pike, Rock		e, MD	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition		NARY ARI							Onset and Death
	/Medical		resulting in death)		or as a conseque		IDBNDD					
	Examiner	L	Sequentially list conditions,	b. GOIT								
	ed isit	lne	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury		URE TO T							
•	xecut and	Examiner	that initiated events resulting in death) Last	C	or as a conseque							
8760,	cate be executed physician and the burial-transit											
9	tificat ng phy as the	Physician/Medical										
Вох	death certific e attending p id for use as l	an/N	IF FEMALE: 23b. Was decedent pregnant		come of pregnan		Ectopic pregnanc	v			23d. Date of deliv	- /
о. П	0 0	sici	in the past 12 months? 1 Yes 2 No	4☐Pregn 9☐ Unkn	ant at time of dea		Other (specify)				Month	Day Year
<u>~</u>	by tac		9 ☐ Unknown Part II. Other significant condition	ens contributing to d	eath but not resul	Iting in the u	nderlying cause an	en in Part I	23e Did	tobacco i	use contribute to	the cause of death?
ds,	signed d be dei	d by	Takin one organization	or sommeting to a	Juli 1 Juli 110 1 1 Juli	ang m aro a	ndonying oxedo gi	on are are a				bably 4 Unknown
20	v requir been s should	ete								20	24h Wara aut	opsy findings available
Vital Records,	The tav	Completed							auto perfe	psy ormed?	prior to co death?	ompletion of cause of
tal	iclen: Th certificate rector, pag	a	25. Was case referred to medical					26. Place of	1 ☐ Yes Death (Check only		1 Tes	Assisted
<u> </u>	nding Physicien: th. : After this certifica s funeral director, (To B	examiner? 1 □ Yes 2🌠 No	Hospital: 1 🗆 I	Inpatient 2 E	R/Outpatien	it 3□ DOA Ott		ng Home 5 Res		6 XOther (Speci	
n of	ng Pl		27. Manner of Death 1 XNatural 5 ☐ Pendin	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	Wo		28d. Describe	how injur	y occurred	
Division	Attending r death. ector: After by the funer	Certification:	2 Accident investig 3 Suicide 6 Could to	jation				Yes 2 □ No	206 1			
Ξ	or Attenuater deatl	rtifl	4 Homicide determ	ined 286. Place	of Injury - At honing, etc. (Specify)	ne, farm, str	eet, factory, office		City or To			al Route Number,
_	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 X Certifyin	g Physician: To the	best of my know	/ledge, death	occurred at the ti	me, date and p	lace, and due to the	cause(s)	and manner as	stated.
	e Horie Fur	edical		Examiner: On the b								
	To the within 2 To the Complet	M	29b. Signature and title of certifier	2_	~		29c. Licens	se number		29d. Dat	te signed (Month,	Day, Year)
)	7		1 - 10H	Caur	(1)		D35	792		M	arch 31,	2004
	V		30. Name and address of person					"===	. 1 . 1 . 1		00050	
		0	Swaroop G. Rao		W. Edmo		Drive,	#504 I	Rockville	, MD	20852	
	Sta Registi		APR 0 2		Epstral's Signatu	19	Sparks	and the same of th				

	1 - For State of Maryland / Depart State of Mary	artment of Health and Mertificate of Death	ental Hygiene Reg. No. 2004 123	116
Physician	1. Decedent's Name (First, Middle, Last)	-	2. Date of Death 3. Time of I	
/Medical Examiner	SOKHA KONG 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	Α "
	JOSEPH RICHEY HOSPICE	BALTIMORE	NONE	
Funeral Director	5. Social Security Number 577-06-7512 6. Sex 1	Months Days Hours Min.	B. Date of Birth (Month, Day, Year) FEB. 2, 1947 9. Birthplace (State or Country) CAMBODIA	Foreign
and	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo		10d. Inside City	y Limits
deeth with the Maryland ms 23e or 28s-f show trives be notified at	MD. PRINCE GEORGES	LANHAM	1 [X Yes	
with the Mar n or 28a-f el be notified Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
5 inter deeth v r Items 23 diver ment	5507 WHITFIELD CHAPEL RD. 11. Marital Status 12. Was Decedent Ever in U.S. 13. 1	20706 Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ri	CAMBODIA fly Yes or No- 14. Race - American Indian,	
and 21215-0036 be filed within 72 hours after death with the Maryla hial Hygiene. so other then "natural", or Items 23s or 28s-1 show event, it a Medical Exercitival man be notified at Be Completed by Funeral Director	If Yes, Give	т Yes, specify Cuban, мехісап, Риело Ні 1 □ Yes 2 Ж No <i>Specify:</i>	Specify:	
5-00 22 hour satural lice Extent		dent's Usual Occupation kind of work done during most of working	ASTAN 16b. Kind of Business/Industry	
Maryland 21215-0036 A 2 should be filed within 72 hours aft th and Mental Hygiene. 77 is marked other then "natural", or traumatic event, it a Medical Exercit traumatic To Be Completed by F	Elementary/Secondary (0-12) College (1-4or 5+)	HOUSEKEEPING	HOTELS	
ind 2121 tal filed within tal filed within d other then " event, its Me. Be Comple	17. Father's Name (First, Middle, Last)		First, Middle, Maiden Surname)	
Aaryland 2 should be 1 2 mad Mendol 1 is marked of 1 1 marked of 1 1 marked of 1	UNKNOWN		UNKNOWN	
Main and 2 st allth and 2.7 le mr traum	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailin SOPHAY PRES/SON 5507	*	Route Number, City or Town, State, Zip Code) RD., LANHAM, MD. 20706	
more, M	20a. Method of Disposition 20b. Place of Dispo			
	A STATE OF THE PARTY OF THE PAR	RS CREMATORY 4-3-2 Name and Address of Facility		_
Balt permit. Depart import import import in suy inji	M. Chambers MO0091 5	HAMBERS FUNERAL HON 801 CLEVELAND AVE.,	E & CREMATORIUM,P.A. RIVERDALE, MD. 20737	
	23a. Pan1. Enter the disease, or complications that caused the death. Do not entended to the shock, or heart failure. List only one cause on each line. Immediate Cause (Final	1	respiratory arrest, Approximate finterval Betwo Onset and De	een
Physician /Medical	disease or condition resulting in death) a. McTastell c (2nd) Due to (or as a consequence of):	cell cancel	> iyr	
Examiner	Sequentially list conditions, it any reading to immediate b. Due to for as a someographic offi.			
S O U	cause. Enter Underlying Cause (Disease or injury that initiated events c.			
3 / 38 / 04 Box 68760, death certificate be executed of for use as the burial-transit clan/Medical Examiner	resulting in death) Last Due to (or as a consequence of):			
8 # \$ # B	d			
S, P.O. Box 6 se that the death certific signed by the attending p be detached for use as by Physician/Mee		Ectopic pregnancy	23d. Date of delivery Month Day Ye	ear .
o. o. the transfer of the state	1 Yes 2 No 4 Pregnant at time of death 5 Unknown	Other (specify)		
ords, P. (conds, P. (conds, P. (conds))	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacco use contribute to the cause of de	
V > 0 2			24a. Was an autopsy findings av prior to completion of cau	
Vital Records Vital Records sicien; The law requires certificate has been sign rector, page 2 should be rector, page 2 chould be			autopsy performed? death? 1 Yes 2 No 1 Yes 2 No	use of
Vita Vita reicien: s certifici director.	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	26. Place of Death (t 3□ DOA Other: 4□ Nursing Home	114.	12
n of n of n of n of n of n of n of n of	27. Manner of Death 1. Natural 5 Pending 28a. Date of Injury 28b. Time of Injury Injury		d. Describe how injury occurred	
Division of tel or Attending F is after death. al Director: After ed in by the funer. Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stri	M 1 Yes 2 No	f. Location (Street and Number or Rural Route Numbe	9 <i>f</i> .
Div Div rs after al Dire led in b	4 Homicide building, etc. (Specify)		City or Town, State)	
Division of Vital Recontinues to the Hospital or Attending Physicien; The taw within 24 hours after death. To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2.	29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death (Check only one) 1 Medical Examiner: On the basis of examination and/or invaner stated.	n occurred at the time, date and place, an vestigation, in my opinion, death occurred	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)	
To the within To the compile	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)	
	> Z LOMO	D24170	March 29, 2004	
	30. Name and address of person who completed cause of death (Item 23a) (Type, I E.TSO MD Richey Hospica 838 NE	Eutaw St Baltin	ere MD 21201	
State Registrar	31. Date filed (Month, Day, Year) MAR 3 0 2084 32. Registrar's Signature	South 1		

			1-	For State RegistraryFND#23a(abc)	State of Mo	-	0-		nt of H				Reg. No	20	04	12	317
	Physicia /Medic			Decedent's Name (First, Middle, Las LEOCADIA JE	AN KUS	SMISK	IS	4h Cib	Town or	Location of		2. Date of De Month MARCH	27		Year 004	3. Time o	f Death
	Examin	er	4a.	Facility Name (If not institution, given 23721 Pleasant						rsbur			40		ontgo	mery	
J.	Funeral Director		1	Social Security Number 6. Se		94	ast birthday) Yrs.		er 1 Year	If Under 2 Hours	4 Hrs. I	B. Date of Bir (Month, Da No v . 30	th ly, Year)			ice (State y) iuani	or Foreign
	aryland show	'n	-	a. State 10b. County Md. Montgo	nerv	1	, Town or L Gaithe		ra						10	d. Inside C	ity Limits
	28e-1	recto	10	e. Street and Number	ilet y				ip Code				10g. Cit	izen of W	hat Count	y?	
	h with	ai Di		23721 Pleasant	View Lane				208	882			t	Inite	d Sta	tes	
2	rs after deal	by Funeral Director	11	. Marital Status t □ Never Married 2 □ Marned 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🕃 If Yes, Give Year or Dates:		S. 13.		edent of Hi ecify Cuba 2200	spanic Orig n, Mexican Specify:	gin? (Spec , Puerto Ri	ify Yes or No ican, etc.)	>-		- America k, White, e		
0000-61717	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment if item 27 is marked other than "natural", or items 23a or 28e-f show any injuly go other treumatic avant, Ita Medical Exertifier must be notified a page.	Completed	-	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or	5+)	(Give	dent's Us kind of v DO NOT	ual Occupa ork done o use retired	ation during most)	of working	7	16b. K		siness/Indu	ıstry	
A	2 should be filed wand Mental Hygie is marked other the eumatic avant, IL.	Be	17	12 Father's Name (First, Middle, Last) Benidict Sidl	0 a						r's Name (First, Middle		Sumam	θ)		
	id 2 should th and Men 27 is marke treumatic	To		9a. Informant's Name/Relationship (Richard E. Kusmis	ype, Print)							Route Numb e, Gai					882
Baitimore,	permit. Pages 1 and 2 Department of Health a Importent: if item 27 ti any injuty of other tre once.		-	a. Method of Disposition 1 Ø Burial 2 ☐ Cremation 3 ☐		20b. P	lace of Disp emetery, cre	osition (N matory of	ame of other plac	θ)	Da				City or Tov		
Ĕ	t. Pag rtment rtent: I		10	* 4 □ Donation 5 □ Other (Specification 1. Signature of Funeral Service Licer)	Воу	ds Pre					/04			Mary	/land	
ğ	Depar Impor any ir		2	> murief &	Bark	er		Muri P. (el H	Barl	ber F 38. L	uneral aytons	Hon Vill	ne le. M	ld. 2	20882	
	Physician		1r	3a. Part1. Enter the disease, or com shock, or heart failure. List only mmediate Cause (Final isease or condition	olications that cause one cause on each I ASPIT	ine.			ode of dyin							Approxima Interval Be Onset and	tween
760,	Medicate be executed attending physicien and for use as the burtal-transit	licai Examiner	if GC th	esulting in death) any, leading to immediate ause. Enter Undertying ause. Closease or injury hait mitated events esulting in death) Last	Due to (or as	PIRAT a conseq VERE	ION uence of): DEMEN	TIA-									
T.O. DOX 00	0 0	Completed by Physician/Med	11/2	FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	death 3	□Ectopic □ Other	pregnancy (specify)					23d. Date Mor	e of deliver	y Day	Year
	es De ga	d by Pr	P	Art II. Dther significant conditions of HYPERTENSION,	ontributing to death			underlying	cause giv	en in Part I.			tobacco Yes 2	_	ibute to the		
Vital Records,	elaw hasb je 2 st	complete	-					-				24a. Was auto perfe 1 Yes	psy ormed?	P	Vere autop rior to com leath?	sy findings pletion of	available cause of
VITA	Physician: The this certificate ral director, pag	Be		Was case referred to medical examiner?	Hospital:				Oth	00	1000	Check onl		-			
	ing Phys	ion: To	2	1 Yes 2 No 7. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Inj (Month, D		28b. Time Injury		28c. Injur Wor	4 🗆 140	28	e 5 p kResi 3d. Describe					
Division of	deat deat ctor: y the	Certification:		2 Accident 3 Suicide 4 Homicide		njury - At he tc. (Specif	ome, farm, s y)	treel, lact	ory, office		28	Bf. Location (City or To			er or Rural	Route Nui	nber,
	To the Hospitel or within 24 hours after To the Funeral Director Completely filled in b	Medical C			nysician: To the bes niner: On the basis and manner s	of examina											s)
•	To th within To th compl	Me	2	9b. Signature and title of certifier	- ed	u ~	w	2	9c. Licens	9 number				nte signed MARC	1 (Month, D H 28		004
	1		3	10. Name and address of person who HUGH HOLDER, M		death (Iter	n 23a) (Type NEGATE	e, Print)				RING,	MD.		905		
	St Regist	ate	3	31. Date filed (Month, Day, Year)	32. Regis	rar's Signa			ocks								

			1 - For State Registrar	State of Marylan	d / Dep Ce	partment of F ertificate of	Health and M Death		Reg. No.	200)4	12318
	Physicia /Medic	_	Decedent's Name (First, Middle, Last, John Alber					2. Date of De Month April	Day	004 Ye	ar	3. Time of Death 10:21A M
1	Examín Funeral Dírector		4a. Facility Name (If not institution, give Southern Marylan 5. Social Security Number 6. Security Number 700-44-6752 1.10	d Hospital	last birthda Yrs.	Clinton	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	9.	e Ge	corge's
7	yianu Mon		Usual Residence of Decedent 10a. State 10b. County		y, Town or	Location			, 1-/	JU - K		1. Inside City Limits
	Sa-f sl	ctor	Maryland Prince G	eorge's		Clintor	1					1 ☐ Yes 2 ☐ No
1	3a or 26	al Directo	10e. Street and Number 9112 Spring Acre	es Road		10f. Zip Code	20735		_	zen of What nited		
0	ges 1 and 2 should be filled within 7.2 hours after death with the Maryanno Lif Health and Mental Hygiene. It feel may 13 is marked other than "natural", or Itama 23a or 28a-f show or other traumatic event, the Medical Evantian must be notified at	by Funeral	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	S. 13	B. Was Decedent of I If Yes, specify Cub		ecify Yes or No Rican, etc.)		14. Race - A Black, W Specify:		c.
20-01-2	tnin /z nou le. len "natural Medical E	Completed b	15. Decedent's Edu (Specify only highest grad	cation	(Giv	sedent's Usual Occup re kind of work done DO NOT use retire	during most of work d)	ing	16b. Kir	nd of Busine		
7	ygien her th		12	3	La	and Survey	T			f Empl	loye	d
ומו	z snould be lited withing and Mental Hygiene. Is marked other than sumatic event, Ita Mi	To Be	17. Father's Name (First, Middle, Last) William	Kepha	rt		18. Mother's Nam	rriet T				
_ (and z sho ealth and h n 27 is me		19a. Informant's Name/Relationship (Ty Emma L. Kephart			iling Address (Street 2 Spring						
υ,	rages 1 and 2 nent of Health int: If item 27 i		20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	tenioval irom State	lace of Dispendency, cr	position (Name of ematory or other pla	ce) Apri	Date 1 8,	20c. Lo	cation - City	or Town	n, Slate
	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licens			22. Name and Addre	2004 ess of Facility Lee a Ferry R	Funera	1 Hor	me,Inc	66	33 Old
	hysician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the deathe cause on each line.	h. Do not e	nter the mode of dyi	ng, such as cardiac	or respiratory a	rrest.	n, Mai	A Ir	pproximate of the state of the
	/Medical Examiner	er	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to (or as a conseq								
,00,00	incate be executed physician and is the burial-transit	cai Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):							
O. DOX 00	The law requires that the death certificate be executed attending physician and attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	1 death 3	EEctopic pregnanc	у		2	3d. Date of Month	delivery Da	
COIDS, T.	quires that en signed by ould be deta	by	Part II. Other significant conditions co.	ntributing to death but not res	ulting in the	underlying cause giv	ven in Part I.			se contribute		cause of death? ly 4 \(\frac{\text{Y}}{\text{Unknown}}\)
	: The law re cate has be page 2 sho	Completed								24b. Were prior death	to comp	y findings available eletion of cause of
N	certifi rector	o Be	25. Was case referred to medical examiner? Y	lospital:	100	Ott	26. Place of Death				_	
5 5	or Attending Proyactan: after death. Director: After this certification by the funeral director.	\vdash	27. Manner of Death **DNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpate 28b. Time Injury	of 28c. Inju	4 ∐ Nursing Ho	me 5 ☐ Resident 128d. Describe i			pecify)	
	I of the flowing and valending Privacient. The law within 24 hours after death, within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - Al ho building, etc. (Specif		street, factory, office		28f. Location (: City or Tou			Rural F	Provide Number,
	lo the Hospital within 24 hours a To the Funeral completely filled	edical (29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, dea tion and/or	ath occurred at the ti investigation, in my o	me, date and place, opinion, death occurr	and due to the ed at the time,	cause(s) date and	and manner place, and c	as state	ed. e cause(s)
1	withis To th	Ň	29b. Signature and title of certifier	\		29c. Licens	59658.		29d. Date	signed (Mo	onth, Da	y, Year)
(0 100		30. Name and address of person who co			e, Print)			(()	. (- /	-	
D	B 10=1		John Lee N	1.D. 61		d Branch	Aveneu Te	mple Hi	11s,	MD 20	748	
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 9 2	2004		Courtes"						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 11:08 M Martine 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AlgioNA medical PENINSULA SAUSBUM NICOMICO If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Days Months 1 2 M 2 □ F Hours 2804 Mary Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 28e-f show 23a or 28e-f show 1 XYes 2 □ No cristiel MD Directo Somer 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21817 324 85+ Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status treumatic event, the Medical Examiners Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 / Yes 2 No Specify: Mexican ō Saltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NIA NIA NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) h and Mental h Be should be AlFredo Mactic Beatriz Lobaton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 100 Carroll St., Salisbury,MD 21804 Karen Guerrero/Social Worker I of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ØCremation 3 ☐ Removal from State 5 rtment rtent: I ' 4 □ Donation 5 □ Other (Specify) 3/1/04 Salisbury, MD Salisbury Crematory njury permit.
Deporte
Importe
any nju 22. Name and Address of Facility
Holloway Funeral Home Professional Association Signature of Funeral Service Licensee Javie 97. CFSP 501 Snow Hill Rd., Salisbury, MD 21804 Compron 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RESMITHTORY DISTress disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** xtrerue Pren Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) signed by the al 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 Yes 2 No 3 Probably 4 Hthknown page 2 should Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 □ No 1 Yes 2 No 1 TYes ision of Vital director 25. Was case referred to medical 26. Place of Death (Check only one) Other: Medical Certification; To 1 Yes 2 No 1 - Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After th 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death. the t 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide ö To the Hospitel within 24 hours at To the Funerel C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ess of person who completed cause of death (Item 23a) (Type, Print) 100 E. CARPON ST.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 3 2004

32. Registrar's Signature

			For State Registrar	State of Maryland	-		of Health of Death		Hygien	200	1232
	Physici		1. Decedent's Name (First, Middle, Last) MARCIA LA	NG				2. Date of Month Marc		^{ay} 2004	3. Time of Death 0410 A M
\ 	/Medio		4a. Facility Name (If not institution, give so Hartley Hall N 5. Social Security Number 6. Sex	ursing Home		Pocom	n, or Location	ity	W	orceste 9. Birth	Place (State or Foreign
	Director		218-03-0923 Usual Residence of Decedent 10a, State 10b, County	M 2DF 84	Yrs.		ays Hours	Min. (Month)	/192		yland 10d. Inside City Limits
	with the Maryla a or 28a-f sho Le notified at	Funerai Director	MD Worceste 100. Street and Number 1006 Market Str	r Poco	moke					Citizen of What Cou	1 No 2 No
036	be filed within 72 hours after death with the Maryland hal Hygiene. dother than "natural", or Items 23a or 28a-1 show other than "natural", or Items 23a or 28a-1 show event, Ite Mcdiral Examinar must be notified at	by Funerai		2. Was Decedent Ever in U.S Armed Forces? 1	ti	Vas Decedent	of Hispanic O Cuban, Mexica	rigin? (Specify Yes or n, Puerto Rican, etc.)		14. Race - Ameri Black, White,	, etc.
21215-0036	ed within 72 ho giene. er than "netur , Ir e Medical I	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give life. L	lent's Usual Ookind of work do DO NOT use re	one durina mo	st of working		Kind of Business/In Stauran	
Maryland	ed la b	To Be (17. Father's Name (First, Middle, Last) James Ardis				Mam	ers Name (First, Mid ie Marin	er		
Baltimore, Mar	es 1 and 2 of Health fitem 27 i		19a. Informant's Name/Relationship (Typ Raymond Ardis/ N 20a. Method of Disposition 1□Burial 2 (Cremation 3□Re 4□Donation 5□Other (Specify)	ephew 20b. Pla	225 A ace of Dispos metery, cren		oad,	er or Rural Route Nu Hampton, Date 3/19/200	VA 20c. l	23666 Location - City or To	own, State
Balti	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service License	Dean	10	Name and Ad	dress of Facil	wHollowa ve., Poc	y Me omok	lson Fu	neral Hom
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of the consequence)	ence of):	er the mode of		t Cardiac or respirator		igia	Approximate Interval Between Onset and Death
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Divis	i Site	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	et, factory, offi	се	28f. Location City or	(Street ar Town, State	nd Number or Rura e)	l Route Number,
	the Hos hin 24 h the Fur npletely	Medical	(Check only 2 Medical Examination)	cian: To the best of my know er: On the basis of examination and manner stated.	ledge, death on and/or inv	estigation, in m	ny opinion, dea	d place, and due to the time to the time.	e, date an	d place, and due to	the cause(s)
	with	<	29b. Signature and title of certifier	Bellen	M.	D	ense number 295	05		ate signed (Month, $8 - 18 - 3$	•
7	H ,	te	AC. Name and Affress of person who come GREGORIO M. BELL 31. Date filed (Month, Day Year)	050, M.D.; 530 32. Restrar's Signatu	2 CHIN	,	DRIV	E, SALIS	BURY	Y, MD :	21801
	Registr	ar	MAK 1 9 21	104 Mineur	D. G	Marie					

LANG, Marcia

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Mary T. Ladany Apr. 2004 8:30 am 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis ElderCare Severna Park Anne Arundel If Under 24 Hrs. 5. Social Security Number 6. Sex If Under 1 Year 7. Age (In vrs. last hirthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days 1 □ M 2X F 232-24-0179 91 Jun. 12,1912 Usual Residence of Decedent 10b. Counts 10c. City. Town or Location 10d. Inside City Limits Anne Arundel 1 ☐ Yes 2 ☑ No Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Arundel Beach Road 21146 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julius Gulas Anna Bodics 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Benkert/Daughter 102 Arundel Beach Road, Severna Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Apr.5, 2004 Gardens of Faith Cemetery Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severma Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) alans Due to (or as a consequence of Due to (or as a consequence of) Due to (or as a consequence of)

Physician /Medical Examiner

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Division of Vital Records, P.O. Box 68760,

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Medical Certification: To

item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Medical Examiner must be nutitled at

permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "n.m. any injury or other traumation.

death with the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of deeth? 3 ☐ Probably 4 ☐ Upknown 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed?

25. Was case referred to medical examiner?
1 ☐ Yes 2 1 No
27. Manner of Death

Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3□ DOA 28b. Time of 28c. Inju

1 🗆 Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

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28a. Date of Injury (Month, Day Yeer) ng igation

Other: Nursing H	lome	5 Residence	6 ☐Other (Specify)
Injury at Work? 1 □ Yes 2 □ No		Describe how inj	

6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)	1 vertifying Physician: To the best of my knowledge, death occu 2 Medical Examiner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, and due to the ation, in my opinion, death occurred at the time	e ceuse(s) and manner as stated. e, date and place, and due to the cause(s)
29b. Signature and	d title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)

29c. License number

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State Registrar

31. Date filed (Month, Day, Year)



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Chance to physicians as: Phillip Los

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Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last, John Dean Long Aa. Fecility Name (If not institution, give 168 CONOWINGO ROAL	street and number)		4b. City, Town, or CONOWIN		2. Date of Deat Month APRIL	Day Yeer 4, 2004 4c. County of Dea CECIL	3. Time of Death 0523 A
Funeral Director		5. Social Security Number 6. Security Number 208-56-6674 Usual Residence of Decedent	7. Age (In yrs. le 4M 2 F 43	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		9. Bir 14, 1960	thplece (State or Foreig ountry) PA
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72 hours after deeth with the Maryland naturel', or Items 23e or 28e-f ehow dical Exact nor must be confliked at	by Funeral	10e. Street and Number 56 Black Burn RC 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	and 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 12 No If Yes, Give Year or Dates:		10f. Zip Code 17566 Was Decedent of His f Yes, specify Cubar	panic Origin? (, Mexican, Pue Specify:		Og. Citizen of What Co USA 14. Race - Ame Black, Whit Specify: Wh	erican Indian, te, etc.
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or Attending Physister death. Director: After this cin by the funeral dire	Certification: To Be	25. Was case referred to medical examiner? X	28a. Date of Injury (Month, Day Year) H - 1 - 0 4 28e. Place of Injury - At hombuilding, etc. (Specify)		3 DOA Other. 28c. Injury a Work? M 1 Ye	4 ☐ Nursing I	28d. Describe how	nce 6 Mother (Special Indiana) occurred Always and Number or Russian State) (108 0 mm)	self
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3 Stat	te	30. Name and address of person who co	AN	lll Pe	nn Street	, Balti	more, Mar	yland 2120	1

		1 - State Registrar					Ce	rtificat	e of l	Death	'	4		004	1606
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Examin	er	4a. Facility Name (If not instit						1		r Location	of Death			unty of Death	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2001 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8:1<u>5pm</u> Annie S. Lea March 25,2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Clinton Nursing And Rehab Center Clinton Prince Georges If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗓 F Months 93 Director 224-36-1532 May 11,1910 Reidsville, NC Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or items 23e or 28a-1 ehow with injury or other traumatic event. It is Medical Exercises must be notified at once. Y Yes 2 No Director MD Prince Georges Seat Pleasant 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6900 Seat Pleasant Drive 20743 <u>United States</u> Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify: Black 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ္က Ben Stephens Esther Stephens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Garner Lea /Son 4043 Grant St N.E. #1 Washington DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 4-3-04 Graves Chapel Cem Rockingham CO.NC 22. Name and Address of Facility Pope Funeral Home 21. Eignature of Funerat Service Licensee 7 2617 Penn. Ave S.E Washington DC 20020 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** heimer S more than Due to (or as a consequence of) /Medical 5 years **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 3 Probably 4 BUnknown 1 ☐ Yes 2 ☐ No Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \subsete \text{No} \) 24a. Was an certificate has 1 Yes 2 No funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Thursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) δ 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 50653 2004 ana GYAN.C SURANA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 585 Deale Churchton 82. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 3 0 2004 Registrar

	·	1 - For State Registrar	State of Ma	aryland /	-		f Health and of Death		Reg. N	200	100
Physicia /Medic Examin	al	Decedent's Name (First, Middle, I MORTON 4a. Fecility Name (If not institution, g	LAFFAL			4b. City, Tow	n, or Location of Dea	2. Date of Domestry MARCH	28,	2004 Year	3. Time of Death 1:15A M
Funeral Director		103-59-4105		e (In yrs. last b	oirthday) Yrs.	If Under 1 Y	SPRING par if Under 24 Hr hys Hours Mir				ERY nplace (State or Foreign untry) V YORK
5-0036 72 hours after death with the Maryland natural; or Items 23a or 28a-f show disal Examinat must be notified at	Director	Usual Residence of Decedent 10a. State 10b. County MARYLAND MONTGO 10e. Street and Number 11621 NEW HAMP		10c. City, To		cation R SPRIN		TI	_	itizen of What Co	10d. Inside City Limits 157Yes 2□No untry? S OF AMERIC
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylan s 1 and 2 should be filed within 72 hours after death with the Marylan Hostinene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinal must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces?	Ever in U.S.		Was Decedent f Yes, specify (of Hispanic Origin? (Cuban, Mexican, Pue			14. Race - Ame Black, White	rican Indian,
d 21215-0036 filed within 72 hours aff Hygiene. ther than "natural", or ont, tra Medical Exami		15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4or 5	; <u>+)</u>	(Give	dent's Usual Or kind of work do DO NOT use re NESS MA	one during most of witired)	orking ame (First, Middle	I	Kind of Business/	·
Maryland Id 2 should be filt Ith and Mental Hy 27 is marked oth traumatic even	To Be	17. Father's Name (First, Middle, La BENJAMTN 19a. Informant's Name/Relationship	LAFFAL			-	ROSE	HA	YNE	or Town, State, Z	
Baltimore, M permit. Pages 1 and 2 Department of Health. Important: If item 27 is any injury or other tre once.	100	ROBERT I. LAFFA 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Dopation 5 Other (Spe 21. Signature of Funeral Service Lice	□Removal from State	20b. Place cernet	of Dispo Pery, crer DAVI	sition (Name of natory or other D MEMOR ANZANSK	piace) 03/3 LIAL GARDE Y ^{es} GOIDBER	Date 0/04 N G MEMORI	FAI AL (Location - City or CLS CHURO	Town, State CH, VIRGINI INC.
Physician /Medical Examiner	Examiner	23a. Parn . Enter the discree, or co shock, or heart failure. List on Immediate Cause (Findisease or condition resulting in death) Sacusation list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	by one cause on each lir a. CARDIO Due to (or as CORONA Due to (or as	the death. Do ne. MYOPATH a consequence RY HEAH a consequence a consequence	e of):	er the mode of	KVILLE PI dying, such as cardi			JE, III Z	Approximate Interval Between Onset and Death
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Records, The law requires ate has been sign page 2 should be	Completed by	Part II. Other significant condition: SEVERE OSTE		ut not resulting	in the u	ndertying cause	egiven in Part I.	1 24a. Was	Yes :	2 No 3 Pro	the cause of death? babbly 4X Unknown topsy findings available completion of cause of 2X No
Division of Vital F or Attending Physician: Th after death. Director: Atter this certificate I in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could no	be 290 Place of Inju	ry y Yeer) 28b	Time of Injury	28c.	Other: 4 Nursing Injury at Work? 1 Yes 2 No	Home 5 Res	idence how inj	ury occurred	ASSISTED
Division To the Hospital or Attending within 24 hours after death To the Funeral Director: After completely filled in by the funeral	ledical Certif		building, etc Physician: To the best eminer: On the basis of and manner sta	of my knowled	ge, deat	n occurred at th	ne time, date and place	City or To	own, Sta	te) s) and manner as	stated.
To the To the Complex	Med	29b. Signature and title of certifier					56197			ate signed (Month	
Sta Registr		30. Name and address of person winds NASREEN KANGO, 31. Date filed (Mottiff, Day, Year)	MD 7610				TE 205, T	AKOMA PA	RK,	MD 20912	2

State of Maryland / Department of Health and Mental Hygiene 2004 12327 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 Month Physician March 29, Leichtfried 2:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Spring House Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 15, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days 1 ☐ M 2 🔼 F Hours Director 213-40-7812 96 1907 Germany Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23s or 28s-1 show any injury or other traumatic avent. The Modical Examinar must be notified as once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 310 Franklin Place 20901 USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Nikolaus Jovy ျှ Margareta Zinnen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gretchen L. Storer/ Daughter 5915 Mentana Street, New Carrollton, MD 20784 20b. Place of Disposition (Name of cometery, crematory or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition Aprilate 2, 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2004 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. AnneMarn ramer 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsal and Death Immediate Cause (Final disease or condition resulting in death) Physician umo wo /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transil Due to (or as a consequence of): Box 68760. the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by , page 2 should 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a a ⊱unaral I 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 To tha 5 29b. Signature and title of certifies 29c. License number 012121 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George F. Sengstack M.D. 3929 Ferrara Drive, Wheaton, MD 20906 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 0 2 2004 sacker Registrar

			1 - For State Registrar	State of Maryland / Depa	artment of Health and Martificate of Death	ental Hygie _{Reg.}	ne 2004 12328
		9	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
U	°Physici /Medi		Richard W	Liska		Month March 2	Day Year 5. 2004 8:20 a M
	Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	march 2	4c. County of Death
v g			2006 Quebec Stree	t	Adelphi	F	rince George's
	Funeral		Social Security Number 6. Se	7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Ye	Birthplace (State or Foreign
L	Director		186-32-4947	M 2□F 62 Yrs.	July House Hill		,1941 Pennsylvania
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation		10d. Inside City Limits
	Aaryl f sho	ō					1 ☐ Yes 2√∑ No
	the t	rect	Maryland Prince G	eorge's Ade	Lphi 10f. Zip Code	100	Citizen of What Country?
	with 3s or	٥				109.	
	ns 2	era	2006 Quebec Stree	12. Was Decedent Ever in U.S. 13. V	20783 Vas Decedent of Hispanic Origin? (Spec	of Yes or No-	USA 14. Race - American Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumetic event, the Medical Example must be rutilly of any once.	by Fur	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? If	f Yes, specify Cuban, Mexican, Puèrto F I □ Yes 2፟፟፟ No <i>Specify:</i>	lican, etc.)	Black, White, etc. Specify:
ğ	2 hou	ted	15. Decedent's Edu	ucation 16a. Deced	lent's Usual Occupation	16b	White . Kind of Business/Industry
212	hin 7	ple	(Specify only highest grad	(Give in life. E	kind of work done during most of workin DO NOT use retired)	g	, , , , , , , , , , , , , , , , , , , ,
2	d with	Com	12	Whole	esale	Pr	oduce
bu	e file al Hy I oth	3e (17. Father's Name (First, Middle, Last)		18. Mother's Name		
<u> a</u>	uld b Ments arkad	To 1	Joseph Liska		Mary ,	Tablon	
Maryland	2 sho and is ma		19a. Informant's Name/Relationship (T)	rpe, Print) 19b. Mailin	g Address (Street and Number or Rural		y or Town, State, Zip Code)
≥ ′	and ealth n 27 ner tr		Lynda Liska	Wife 2006 (uebec Street Ade	lphi,Mar	yland 20783
ore	T is it		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	20b. Place of Dispos cometery, crem	sition (Name of Date)		Location - City or Town, State
altimore,	Pag ment ant: ury		'4 □Donation 5 □ Other (Specify)	George Was	Shington Cemetery Mar. 20	2004 44	elphi,Maryland
ä	armit.		21. Signature of Fune al Service Licens	ee) 22.	Name and Address of Facility Ancis J. Collins Fu	noral Ha	mo Tmo
<u> </u>	20 E 20		(a)	500) University Blvd.	W. Silve	r Spring MD 20901
Н			23a. Part1. Enter the disease, or complessock, or heart failure. List only o	lications that caused the death. Do not ente ne cause on each line.	er the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	a Respiratory Failure	a		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):			
ß	Examine	L		Chronic Lymphocytic	Leukemia		
	Sit 9d	inei	cause. Enter Underlying	Due to (or as a consequence of):			
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	3			
8760,	cate be executed physician and the burial-transit		,	Due to (or as a consequence of):			
8	cate physi	dical		1			
9 ×		/Me	IF FEMALE:	23c. If yes, outcome of pregnancy			
Box	death certifi e attending id for use as	Physician/Me	in the past 12 months?	1 Live birth 2 Fetal death 3 □	Ectopic pregnancy		23d. Date of delivery Month Day Year
o.	0 0 0	ysic	1 Yes 2 No 9 Unknown	4☐ Pregnant at time of death 5☐ 9☐ Unknown	Other (specify)		
<u> </u>	law requires that the as been signed by th 2 should be detache	h h	Part II. Other significant conditions con	ntributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
g	uires sign d be	d by		×	, • •	l.	2 No 3 Probably 4 Unknown
Ö	w require been sig should t	ete					
Records,	0 - 0	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
	ician: Th certificate rector, pag		05.14			1 Yes 2√21	
Vital		Be c	25. Was case referred to medical examiner?	dospital:	26. Place of Death (
ō	Phys	5 To	1 ☐ Yes 2 🛣 No	1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury 28b. Time of	3 DOA 4 Nursing Home	 5 Residence d. Describe how in 	6 □Other (Specify)
o	ding f th. After funer	tior	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No	3. D0301100 110W II1	ary occurred
DIVISION	or Attending ifter death. Diractor: Aftel in by the fune	ertification:	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, stre		f. Location (Street	and Number or Rural Route Number,
É	tal or Attendii s after death. al Diractor: A ed in by the fu	erti	4 Homicide determined	building, etc. (Specify)		City or Town, Sta	ite)
	the Hospital in 24 hours a the Funaral D npletely filled i	alc	29a. Certifier 1 Certifying Phys	sician: To the best of my knowledge, death	occurred at the time, date and place, an	d due to the cause	(s) and manner as stated
	ne Ho	edical	(Check only 2 Medical Examinations)	sician: To the best of my knowledge, death ner: On the basis of examination and/or inve and manner stated.	estigation, in my opinion, death occurred	at the time, date a	nd place, and due to the cause(s)
	To the P within 24 To the 5 complete	Me	29b. Signature and title of certifier		29c. License number	29d. D	Date signed (Month, Day, Year)
	W) mulio	1 Kan	D 227/2	7.5	1 06 0004
	, -		30. Name and address of person who co	empleted cause of death (Item 23a) (Type, P	D 23743	Ma	rch 26, 2004
			Martin D. Weltz,	M.D7525 Greenwa	y Court Drive Gre	enhelt Ma	rvland 20770
-	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature		كالاو التاسيد	Tyland 20//0
	Registr	ar	MAR 2 9 200	4 Seneva B	Sparks		

			1 - For State Registrar	State of Maryla	nd / Depa	artment o	f Health and of Death	d Mental Hyg	giene Reg. No. 2001	12329
	Physic /Medi		Decedent's Name (First, Middle, Last Ra					2. Date of Dea Month March	nth Day Year	3. Time of Death
	Exami		4a. Facility Name (If not institution, give Manor Ca		JVIIIS	4b. City, Tow	m, or Location of De Bethesd	ath .a	4c. County of Dea	5:55 PM gomery
	Funeral Director	35	5. Social Security Number 6. Se 278-05-5502 Usual Residence of Decedent	7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Y Months Da	ear If Under 24 H lys Hours M	rs. 8. Date of Birth	y, Year) 9. Bir	thplace (State or Foreign buntry) st Virginia
	the Maryland 28a-f show natified at	Director	10a. State 10b. County	gomery 10c. (City, Town or Lo		Bethesda		log. Citizen of What Co	10d. Inside City Limits 1 Tyes 2 XNo
Maryland 21215-0036	a within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show the Mayleal Examiner must be notified at	Completed by Funeral Di			II 16a. Deced	Was Decedent f Yes, specify (20817 of Hispanic Origin? Cuban, Mexican, Put No Specify:	(Specify Yes or No- arto Rican, etc.)		States oncan Indian, e, etc. White
and 21;	77 75 14 144	Be	12 17. Father's Name (First, Middle, Last)	Onage (1 401 54)		Cred	it Manage 18. Mother's N	ame (First, Middle, I	Maiden Sumame)	L Oil
di.	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic avent, once.	To	Char 19a. Informant's Name/Relationship (Ty Gary Lovins/ Son 20a. Method of Disposition 1 (X)Burial 2 Cremation 3 Price (Specify) 21. Signature of Furjeral Service License	Removal from State 20b.	5903 Place of Dispos cemetery, cren aryland eterans	Ryland sition (Name or natory or other) Cemete	Drive Be	Bural Route Number Lesda, Ma Date ch 2004	nknown City or Town, State, 2 cryland 2() Coc. Location - City or Cheltenham Cumphrey Fu 7557 Wisco	Town, State
8760,	cate be executed hysician and hysician and the burial-transit the burial-transit	cal Examiner	23a. Part 1. Enter the disease, or complisheck, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (classed or injury that indiated events resulting in death) Last	Due to (or as a conse	quence of):	or the mode of	dying, such as cardi	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
Box 6	death certific e attending p d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of	al death 3 🗌	Ectopic pregna Other (specify)			23d. Date of deliment	very Day Year
Ś	The law requires that the ate has been signed by the page 2 should be detache	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the un	derlying cause	given in Part I.	23e. Did tob	acco use contribute to s 2 No 3 Pro	the cause of death?
al Reco	ysician: The law re is certificate has be director, page 2 sh	Completed	05 Wassesseless					24a. Was an autopsy perform	r prior to content? death? death? 1 ☐ Yes	opsy findings available ompletion of cause of
Division of Vital Record	문 문 교	atlon: To Be	25. Was case referred to medical examiner? 1	ospital: 1	ER/Outpatient 28b. Time of Injury	28c. In	Other: 4 🛛 Nursing I	ath Check only one Home 5 Resider 28d. Describe how	nce 6 Other (Speci	ify)
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	(Y)			City or Town,	-	
	the Hosp hin 24 hou the Fune mpletely fi	Medical	one)	ician: To the best of my kno ler: On the basis of examina and manner stated.	owledge, death ation and/or inve	estigation, in my	opinion, death occ	urred at the time, dat	te and place, and due t	o the cause(s)
}	でずり		29b. Signature and title of certifier	2		84	7378	29	d. Date signed (Month, March 2	
	Sta Registra	e	30. Name and address of person who core Gul Chablani, M.D. 31. Date filed (Month, Day, Year) MAR 29 200	11119 Rockv	ille Pi	•		e, Maryla	nd 20852	

State of Maryland / Department of Health and Mental Hygiene 2004 12330 Certificate of Death 2. Date of Death 2004 Year 25, March

Physician /Medical Examiner

Funeral

Director with the Maryland show s 23a or 28a-f shor death 1 or Items other traumatic event, the Medical Examiner filed within 72 hours after "natural" than permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event once.

Maryland 21215-0036

altimore,

Box 68760,

P.O.

Division of Vital Records.

Physician /Medical Examiner

the death certificate be executed physicien and s the burial-trans use as for signed by t this certificate has been siral director, page 2 should After To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft

1. Decedent's Name (First, Middle, Last) 3. Time of Death Lan Hoang Luu 9:00 P M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Mariner Health Care of Silver Spring Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 🖾 F 586-44-2761 70 May Vietnam Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2103 Prichard Road 20902 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑ Never Married 2 ☐ Married þ 1 ☐ Yes 2X No Specify: It Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Asian Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Trac Luu Thi Doan Phan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Luu N. Paul/ Sister 2103 Prichard Road, Silver Spring, Maryland 20902 20b. Place of Disposition (Name of camelery crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State March 29, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 2004 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 21. Signature of Funeral/Servic Vic-see M00689 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, but head failure. List only one cause on each line. 23a. Part Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pulmonary Fibrosis resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs, coasts fir july that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 4 Pregnant at time of death 1 Yes 2X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Hospital: ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical title of certifier 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)
MAR 29 2004

Martin C. Shargel, M.D.

raite

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

3720 Farragut Avenue, Kensington, Maryland 20895-2110

D08944

March 26, 2004

			For State Registrar		Maryland / Dep		lealth and M	lental Hy	giene	104 12	221
			Decedent's Name (First, Middle)	, Last)		Timouto or i	Douin	2. Date of Dea		3. Time	of Death
	Physic		Carrie	Beatrice	T.	itton		March	Day 21	Year 2004 180	
	/Medi Exami		4a. Facility Name (If not institution,				r Location of Death	10:011	4c. County		1.
			Washington Coun	ty Hospita	1	Hagersto	wn		Wash	ington	
	Funeral		,	6. Sex 7.	Age (In yrs. last birthday,		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		Birthplace (State Country)	or Foreign
	Director		313-30-1013	ILIM ZLALF	95 Yrs.	William Bays	TIOUTS IVIII.	Nov. 2	1,1908	Maryland	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside (City Limite
	Maryl f sho	ō	MD Washin	eton	Hagerstov						s 2 XNo
	the 28a	rec	10e. Street and Number	5-0-1	nagerseov	10f. Zip Code			10g. Citizen of W		
	3 with	O	1039 Mt. Aetna	Road		21740			U.S.		
	death	Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14. Race	- American Indian,	
9	after or Its	Fu	1 ☐ Never Married 2 ☐ Marrie	Armed Force ad 1 Tes 2 If Yes, Give	∑ No	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		Rican, etc.)		k, White, etc.	
93	ural',	d by	3 XWidowed 4 ☐ Divorced	Year or Date	es.	THES ZENINO	Specify:		Specify:	White	
5-	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or flams 23a or 28a-f show ont, the Medical Exeminar must be notified at	Completed	15. Decedent' (Specify only highest	s Education grade completed)	16a. Dece (Give	dent's Usual Occupa	ation during most of work	ing	16b. Kind of Bu	siness/Industry	
12	withir ane. than	E G	Elementary/Secondary (0-12)	College (1-4	or 5+)	DO NOT use retired. Person	1)				
d 2	filed with Hygiene. other than		17. Father's Name (First, Middle, L	ast)	bares	, rerson	18. Mother's Name	e (First Middle	Keyston		
lan	id be ental ked c	To Be	George Washingto	on Petre			Mamie F1			-,	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Ifeath and Mental Hygiene. Ifem 27 is marked other than "natural", or Itams 23s or 28s—f show other traumatic event, Ira Medical Examiner must be notified at	-	19a. Informant's Name/Relationsh		19b. Maili	ng Address (Street a			r, City or Town, S	State, Zip Code)	
	is 1 and 2 of Health a item 27 is other train		Velena M. Mille:	r/Daughter	1	Mt. Aetna				1742	
ore			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Demond from St	20b. Place of Dispo	sition (Name of matory or other place	1			City or Town, State	
Ē	Pag nent ant: I		`4 □ Donation 5 □ Other (Sp.		ILE	en Cemete:		2004	Hagersto	own, MD	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Li	icensee	22	2. Name and Addres	ss of Facility Re	st Have	n Funera	1 Chapel	
	₹0 E ≘ a		Slephon M	· Sum	1	601 Penns	vlvania A	ve Hag	erstown	MD 21742	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	_a _ / V/V	as a consequence of):	received	186	tespiratory arri		Approxima Interval Be Onset and	tween
68760,	ificate be executed physician and ss the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underkring Cause (Tisesse of Injury that initiated events resulting in death) Last	c	as a consequence of): as a consequence of):	W					
.O. Box	that the death certificate ed by the attending phy detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery h Day '	Year
Records, P	w requires that the been signed by th should be detache	by	Part II. Other significant condition	s contributing to death	but not resulting in the un	aderlying cause give	n in Part I.			oute to the cause of o	
000	> 4	ompleted						24a. Was a		ere autopsy findings	available
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Vital	ystcian: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?				26. Place of Death			JYes 2□No	
of V	ys dill	70	1 Tes 2 No		atient 2 ER/Outpatien	t 3 DOA Other	r: 4 Nursing Hor	ne 5 🗆 Reside	nce 6 Other	(Specify)	
	ing P	ino i	27. Manner Teath 1 Natural 5 Pending	28a. Date of li (Month, I	njury 28b. Time of Day Year) Injury	28c. Injury Work		8d. Describe ho	w injury occurred	i	
Sic	Attending r death. actor: After by the fune	icat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t ho			es 2□No				
Division	al or A s after al Direct	Certification;	4 ☐ Homicide determin	ed 286. Place of building,	Injury - At home, farm, streetc. (Specify)	eet, factory, office	2	City or Town	eet and Number , State)	or Rural Route Num.	ber,
	To the Hospital or Attending Phwilin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the be caminer: On the basis and manner	st of my knowledge, death of examination and/or inv stated.	occurred at the time restigation, in my opi	e, date and place, a inion, death occurre	nd due to the ca	use(s) and mannite and place, an	ner as stated. d due to the cause(s)
		Σ	29b. Signature and title of certifier	my	MD	29c. License.	number 80	29	Date signed (Month, Day, Year)	
54	, 0		30, Name and address of person w	no completed cau	the ath (Item 23a) (Type,)	21 Oal	Khill	ave	14/99	ess towa	7
*	Sta Registr	16	31. Date filed (Month, Par Year)	3 2004 32 Reg	strar's Signature	Grande		/	0	M)21	742

buoisi	210	1 - For Amend Item 5 per Registrar 1. Decedent's Name (First, Middle, Last)	^	Timoate of Death	2. Date of Death Month	p. No. 2001	3. Time of Death
hysici /Medio		Clella Ma	e Lehardy	/	Apr.	5, 2004	
Examir	ier	4a. Facility Name (If not institution, give street a		4b. City, Town, or Location of Death		4c. County of Deet	_
	,	1232 Taylor Aven 5. Social Security Number 6. Sex	UO 7. Age (In yrs. last birthday)	Arnold If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Anne 9. Birth	Arundel
ineral rector		5 Social Security Number 415-12-60-8 212-20-0610 Usual Residence of Decedent		Months Days Hours Min.	8. Date of Birth (Month, Day,) Dec. 18,	1920 Co	hplace (State or Fore untry) TN
f show	tor	MD 10b. County Anne Aruno	10c. City, Town or Lo	Arnold			10d. Inside City Lim 1 ☐ Yes 2 ☐
a or 28a	Director	10e. Street and Number 1232 Taylor Avenue		10f. Zip Code 21012	10	g. Citizen of What Co	untry?
ms 2	Funeral	11 Marital Status 12. Wa	s Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No-	14. Race - Ame	rican Indian,
ir than "natural", or Items 23a or 28a-f show the Medical Examinat must be notified at	by	1 Never Married 2 Married 1 If Y	Yes 21X No	If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 🏿 No Specify:	tican, etc.)	Black, White	white
n natur Medical I	Completed	15. Decedent's Education (Specify only highest grade comp	leted) (Give	dent's Usual Occupation kind of work done during most of workit DO NOT use retired)	16	6b. Kind of Business/	Industry
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d other	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name		aiden Sumame)	
	2	Thomas G. Rice		Althea T			
item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Pri		ng Address (Street and Number or Rura			(ip Code)
item 27 other tr		Effic Federline/Sist	cer 1232 20b. Place of Dispo	2 Taylor Avenue, Au		Dc. Location - City or	Town State
ii io		1 ဩBurial 2 ☐ Cremation 3 ☐ Remova	from State cemetery, crei	matory or other place) en Cemetery		Glen Burni	
njury		*4 □ Donation 5 □ Other (Specify) 21. Stynatury of Funeral Service Licensee					
Importent: If ite eny injury or of once.		2/a. Pa / I. Enter the disease, or complications s ock, or heart failure. List only one caus	VIGNED 49	Arrancodom Sons, P. 1 95 Gov. Ritchie Hwy	, Severi	na Park, M	neral Hon D 21146 Approximate
physician and edical the purial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of): Oue to (or as a consequence of):	1 Inform			Onset and Death
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g e	b	Part II. Dther significant conditions contribution	ng to death but not resulting in the u	inderlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death
ate has been si page 2 should	Completed	Hypertyroiden			24a. Was an autopsy performe	prior to o	topsy findings avail completion of cause
certificate rector, pag	Be	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)		
this al dir	ဥ	1 Yes 2 No Hospita	1 Inpatient 2 ENOutpatier		ne 5 Aesiden 8d. Describe how	ce 6 Other (Spec	city)
After	lon	1 Natural 5 Pending	(Month, Day Year) Injury	Work?	od. Describe now	V/A	
Director: in by the	Certification:	2 Could not be	Place of Injury - At home, farm, str building, etc. (Specify)		8f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
e Funerel etely filled	Medical Co	(Check only 2 Medical Exeminer: O		h occurred at the time, date and place, a vestigation, in my opinion, death occurre			
- 5	Me	29b. Signature and title of certifier	d mannor stated.	29c. License number	290	d. Date signed (Month	n, Day, Year)
o the formotel	4			7		4/6/04	
To the f				120054088		1/0/07	
To the F		30. Name and address of person who complete	d cause of death (Item 23a) (Type.	D0058 088		17070 7	oddberg 1

DHMH 17 Rev 1/2001

ORIGINAL

			Please 1 - For State Registrer	Type or Prin		d / Dep	ndelible Ink. partment of F ertificate of	lealth and	Mental Hy		200	l: -1	233
	Physici /Medic		Decedent's Name (First, Middle, Last Hamilton Lindho	rst					2. Date of De Month March	28,	y Yeer 2004	3. Time o	of Death A M
-	Examir Funeral	er	4a. Fecility Name (If not institution, give 108 Dogwood Dri 5. Social Security Number 6.5	ve ex 7. Age		last birthda	Hurlock	If Under 24 Hrs	8. Date of Bir	Do	Co		or Foreign
	Director work	or	Usual Residence of Decedent 10a. State 10b. County	82	10c. City	y, Town or			Oct. 1.	5,19	21 Mary	7 Land 10d. Inside 0 1 🛱 Yes	City Limits
)	within 72 hours after death with the Maryland ene. than "natural", or itams 23e or 28e-f ahow fre Modical Exercite reseat be notified at	Funeral Director	Maryland Dorchest 10e. Street and Number 108 Dogwood Drive			urloc	10f. Zip Code 2164:				izen of What Co		
0500-c1	ours after de ral', or Itams	þ	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:	19	s. 940 945	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🂢 No	ispanic Origin? (S in, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.))-	14. Race - Amer Black, White Specify: Wh		
1-01717	d within 72 h giene. rr than "natu	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		+)	(Giv life.	edent's Usual Occup re kind of work done o DO NOT use retired keeper	during most of wor	rking		ind of Business/l Employe		
ryland	hould be file d Mental Hyg narked othe natic event,	To Be C	17. Father's Name (First, Middle, Last) Henry Lindhorst, 19a. Informant's Name/Relationship (Sr.		10h M-	iling Address (Street	Helena	me (First, Middle, Trimble			in Code	
ore, mai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other treumatic event, the Medical Exactine mast be notified at once.	1	Dorothy E. Lindho 20a. Method of Disposition 1 XBurial 2 Cremation 3 C	rst/Wife	C	108 lace of Disp	Dogwood Di position (Name of ematory or other place	rive, Hun	clock, M	ary1		43	
Бащто	permit. Pag Department Importent: any injury o		*4 □Donation 5 □ Other (Specify 21. Signature 1 Funeral Service Lices	()	Un:	Z	ashington ^{22 Name and Addres} eller Fune 06 Main Si	ss of Facility	e, P. O.	Вох	lock, Ma		
を	Physician /Medical Examiner		23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each line. a	ep:	Do not e		g, such as cardiad	or respiratory a	rrest,		Approxima Interval Be Onset and	tween
08/00,	cate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a Due to (or as a d.		uence of):	VADC	u (**)	rice io	en		130	JCAIS
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упал не	sician: The law certificate has b irector, page 2 sl	Be	Productic 1 25. Was case referred to medical examiner?	typortr	oph	4	000		1 ☐ Yes ath Check on o	rmed? 2 V o one	prior to co death? 1 \(\text{Yes}	2 No	ause of
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Z Z	spital or Att nours after d neral Direct filled in by t		3 Suicide 6 Could not be determined	building, etc	of my know	/) 	itreet, factory, office	ne, date and place	City or Tow	vn, State	and manner as	stated.	
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	Sta	ite	30. Name and address of person o	D.O.	eath (Item IOC ar' a ignat		Shamble Shaell	5 τ	Cam	brid	lge !	MD	
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			For	State of N	Maryland /	Depa	artmen	t of H	ealth a				ie .		
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	Physic /Medi	cal	Decedent's Name (First, Middle, La Aileen Algire La 4a. Fecility Name (If not institution, gi	eister	ar)		4h City	Town or	Location of		2. Date of De Month April		5 200	4 11:	of Death
	Exami	ner	Anne Arundel Med		,		_	apol		Death			ic. County of De Anne Ar		
	Funeral		Social Security Number 6.	Sex 7.	Age (In yrs. last bi	irthday)	If Under	1 Year	If Under 2		8. Date of Bir	rth		irthplace (Stat	te or Foreign
	Director		220-03-2173 Usual Residence of Decedent	1 □ M 2 🗗 F	91	Yrs.	Months	Days	Hours	Min.	(Month, Da		1912 M	arylano	d
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	er death w	erai	4 Dale Drive	12. Was Decede	nt Ever in U.S.	13 \		403	nanic Origi	in? (Spec	ify Vee or No		ited St		
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pu	should be filed nd Mental Hygis marked other matic event, II	To Be C	17. Father's Name (First, Middle, Las. Jacob Frank Algi.	1)		ar c	-66661			's Name	(First, Middle X				
lary	2 should and Men is marke eumatic		19a. Informant's Name/Relationship		198	b. Mailir	ng Address	(Street a	nd Number	or Rural	Route Numb	er, City	or Town, State,	Zip Code)	
	1 and Health em 27 ther tr		W. Brooke Leiste	r, III, s					re. An		lis, M				
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	Physician /Medical Examiner		23a. Pert1. Enler the disease, or con shock, or heart lailure. List only Immediate Cause (Final disease or condition resulling in dealh)	a.	Pheumo as a consequence	ma	er the mode	or dying	, such as ca	ardiac or	respiratory a	rrest,		Approxim Interval B Onset an	Between Id Death
760,	ate be executed nysician and he burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease of injury that initiated events resulting in death) Last	с.	as a consequence										
P.O. Box 687	The faw requires that the death certificate be executed are that been signed by the attending physician and page 2 should be detached for use as the buriat-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown		2 Fetal death at time of death		Ectopic pre						23d. Date of de Month	elivery Day	Year
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on of	ng Phys Itter this Ineral di	tion; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpa 28a. Date of In (Month, I	jury 28b.	utpatient Time of Injury	-	c. injury : Work?	4 🗆 Nurs	28	5 ☐ Resid d. Describe h		6 Other (Spe	ocify)	
Division	of or Attending after death. Director: A din by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	e 28e. Place of I	njury - At home, la elc. <i>(Specify)</i>	arm, stre	et, factory,				f. Location (S City or Tox	Street a. vn. Stat	nd Number or R e)	ural Route Nu	ımber,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the bearings: On the basis and manner:	of examination an	e, death nd/or inv	occurred a estigation,	t the time in my opi	, date and p nion, death	place, an	d due to the o at the time, o	cause(s date an	s) and manner as d place, and due	s stated. e to the cause	o(s)
)	To th within To the compl	Me	29b. Signature and title	Bech			29c.	License	number U 60 S	52	3	29d. Da	ate signed (Mont		
			30. Name and address of person who	completed cause of	death (Item 23a) 2001 Me	Type, F	al) Pou	rkw	ay,	ann	apolis	, 1	10		
	Sta Registi		31. Date filed (Month, Day, Year) APR 0 7		trar's Signature	8	hook	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Item 12 per FH G830.04/22/04dhb
State of Maryland / Department of Health and Mental Hygiene Amend Item 12 Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 6:30 P. M APRIL 4 2004 -vea /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner QUEEN ANNES 116 HOLDEN FARM LANE OUEENSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months 1 M 2 □ F 220-16-5708 MARYLAND 91 OCT 16 1912 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location of Health and Mental Hygiene.
Item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Madical Explainer must be notified at 1 Yes 2 No Be Completed by Funeral Director MARYLAND QUEEN ANNES OUEENSTOWN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 116 HOLDEN FARM LANE 21658 U.S. 12. Was Decedent Ever in U.S. Armed Forces? 1 XIYes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "natural", or Item any injury or other traumatic event, the Madical Examinations. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify WHITE 3 □ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) OWNER/OPERATOR CAR DEALERSHIP 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES MORTON JEANNE McMURDO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) FREDERICK J. MORTON / SON 116 HOLDEN FARM LANE, QUEENSTOWN, MD 21658 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) FROSTBURG MEMORIAL PARK 4/7/04 FROSTBURG, MD 21. Signalure of Funeral Service Licenses 22. Name and Address of Facility 60 W. MAIN STREET Sowes MA SOWERS FUNERAL HOME, P.A. FROSTBURG, MD 21532 23a. Part . Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Advanced **Physician** Dementio disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Teans erten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that interest and cause) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Years 2 fee Me that initiated events resulting in death) Last Du to (or as a consequence of) P.O. Box 68760, Month RIWARY IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day Year in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Disease 24a. Was an page 2 s autopsy performed this certificate CAICI NOM 1 Yes 2 No 1 ☐ Yes 2 ☐ No llena Mans To the Hospitel or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٤ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending 1 🗌 Yes 2 🗆 No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier V0059420 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Centerille Pennsylvania 21617 DAVID A COSENZA 420 MD 31. Date filed (Month, Day, Year) APR 2 2 2004 32. Registrar's Signature State Registrar

		• •	/ Department of Health and M Certificate of Death	lental Hygie	•	12331
Physici	ian	1. Decedent's Name (First, Middle, Last) Otis Harry Marine		2. Date of Death . Month	Day Year	3. Time of Death
/Medic Examir Funeral Director		4a. Facility Name (If not institution, give street and number) 5. Social Security Number 6. Sex 1 MM 2 F 56	4b. City, Town, or Location of Death A more of Death A	8. Date of Birth (Month, Day, You Oct. 7,	4c. County of Death Do Che ear) 9. Birthpl County	ace (State or Foreign
ъ	ctor	Usual Residence of Decedent	Town or Location Cambridge	000. 1		od. Inside City Limits
with the	al Dire	10e. Street and Number 209 Virginia Ave.	10f. Zip Code 21613	10g.	Citizen of What Count	ry?
nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artenet of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or Items 23e or 28e-f show injury or other traumatic event, the Medical Examinational be natified at a.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Yes 2 Mo 1 Yes, Give 1 Yes or Dates:	13. Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerlo	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	tc.
filed within 72 hours after Hygiene. other than "natural", or Ite ant, the Medical Examina	Completed		Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 168	b. Kind of Business/Ind	ustry
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2 should and Men is marke sumatic	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rura	J. Arnett al Route Number, C	ity or Town, State, Zip	Code)
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permit. Pages 1 ar Department of Hea Important: If item any injury or other		21. Signature of Funeral Service Licensee Date of Funeral Service Licensee	y Washington Cem. 4/1/ 22. Name and Address of Facility The 700 Locust St., Ca	nomas Fune	urlock, MD eral Home P MD 21613	.A.
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he Hospit in 24 hours he Funera pletely fille	ledical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowl on the dasis of examination and manner stated.	edge, death occurred at the time, date and place, and and/or investigation, in my opinion, death occurr	and due to the caus ed at the time, date	e(s) and manner as sta and place, and due to t	ted. he cause(s)
To the To the Comp	W	29b. Signature and title of certifier Walker M D	29c. License number D 47924		Date signed (Month, D	ay, Year)
		30. Name and address of person who completed cause of death (Item 2 NOMAN TIARNWT 300 AURO	13a) (Type, Print) ORA STREET CAT	BRIDGE	NAD 2	1613
Sta Regist		31. Date filed (Month, Day, Year) MAR 3 0 2004 Registra's Signature	to book			

		_1	For State Registrar	State of Man	yland / Depa		lealth and I	Mental H	Reg.	ne 200	
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	ledica	al -		ARGARET	MASON				28,		2:50 P ^M
Ex	amine	er '	4a. Fecility Name (If not institution, give	-			r Location of Death	1	Ι,	4c. County of De	
			8601 Seabay Drive 5. Social Security Number 6. Se.		n yrs. last birthday)	Ocean If Under 1 Year		9 Date of F		Worceste	
Fund Direct	_			M 2√ F 79	Yrs.	Months Days	Hours Min.	8. Date of E (Month, I Nov.	22,	1924 M	irthplace (State or Foreign Country) aryland
land ow	H	-	10a. State 10b. County		Oc. City, Town or Lo						10d. Inside City Limits
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n the	laga.	<u>e</u>	10e. Street and Number			10f. Zip Code			10g.	Citizen of What	Country?
h witi	2	무	8601 Seabay Drive	9		21842			U	.S.A.	
deat	3	Funeral Director	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13. \	Was Decedent of H	Hispanic Origin? (Si an, Mexican, Puert	pecify Yes or I	Vo-	14. Race - Ar Black, Wi	nerican Indian,
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should lind Men	natio	၉ -	19a. Informant's Name/Relationship (T)	one Print)	19h Mailir	on Address (Street	Lucy Be		her Ci	v or Town State	Zin Codel
C/ 00 -	traul		M. Lynn Mason Go			Shady		ewton,			_
Te, No sand Health Health tem 27	ther	1	20a. Method of Disposition		20b. Place of Dispo	sition (Name of		Date	-,	Location - City	
Baltimore, permit. Pages 1 ar Department of Hea Important: If item:	707		1 Burial 2 Cremation 3 F	Removal from State	Cape Hen	natory or other pla	Mar.:	3,2004	En	nkford,	DE
Itin	injury F	-	21. Signature of Fune Ai Service Licens		cape Hen	. Name and Addre	ess of Facility		Fre	108 Will	
Balt permit. Departr Imports	once once		1 KINGS	.hal			ge Fune	ral Hor	ne	Berlin,	
Physic /Med Exami	ical		23a. Pant. Enter my disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ication that caused the ne caused the ne caused line. a. Due to (or as a c	laugio			or respiratory	arrest,		Approximate Interval Batween Onset and Death
760, te be executed sician and	e burial-transit	cal Ex	Sequentially list conditions, if any, leading to immediate case. Line u designing Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a c							
I Records, P.O. Box 68 The law requires that the death certificat ate has been signed by the attending phy	ched for use as t	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1	Fetal death 3	Ectopic pregnanc	y		-	23d. Date of d Month	elivery Day Year
that!	deta	Y P	Part II. Other significant conditions co	ntributing to death but r	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacc	o use contribute	to the cause of death?
ds uires uires	ed be	d b						10	Yes	2 No 3	Probably 4 Sunknown
Rec The lav		Completed						24a. Wi au pe 1 🗆 Yes	lopsy rformed	? prior to	autopsy findings available o completion of cause of
/ita cian: artific	actor,	Be (25. Was case referred to medical examiner?				26. Place of Dea	th (Check only	/ one)		
- × v	dire	ဥ	1 Yes 2 No	Hospital: 1 ☐ Inpatient		I 3 DOA	ner: 4 ☐ Nursing H			6 □Other (Sp	pecify)
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Division of Vital to Attending Physician: after death. Director: After this certifica	by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, str (Specify)		Yes 2 □ No	28f. Location City or 7			Rural Route Number,
ospita hours uneral	aly filled in			sician: To the best of r							
To the Hi within 24 To the Fe	npleti	Medical	one)	and manner stated	1.						
To with	00	2	29b. Signature and title of certifier			29c. Licens		7	29d.	Date signed (Mo	nin, Day, 19ar)
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CT 1	~		30. Name and address of person who c	R	1	Print)	1209	Cous	tock	Atoghe	way
ET 1			31. Date filed (Month, Day, Year)	32. Registrar's		NA	Ituvia	n +	bec	wy De	119944
Re	Sta gistra			04 Steelstrans	o K do	made y					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** MAKIH 0110 13 WILLIAM HENRY MARSHALL, JR. 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PENINSULA REGIONAL MEDICAL CONTE 542136414 WICOMICS If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □XM 2 □ F Yrs. 8/23/1938 230-48-1261 Virginia 65 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other treumatic event, the Madical Examiner must be notified at 1 TYes 2X No Director VA Accomack Greenbackville the 10e. Street and Number 10f Zio Code 10g. Citizen of What Country? USA 23356 or Items 23a 1379 Ellis Street Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔼 No ģ Specify: 3 Widowed 4 Divorced white naturel Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than Self Employed/Management Waterman/Seafood 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Myrtle Virginia Holloway Marshall, Sr. William Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 102, 1379 Ellis St., Greenbackville, VA 23356 At of Head of Head 2) violatery or of P Janice Marshall (wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) 3/16/2004 Greenback-Union Cemetery Greenbackville, VA 21. Signature of Fundral Service Licensee ²² Name and Address of Facility
HOIloway Melson Funeral Home, P.A. Dean 103 Linden Ave., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCVA **Physician** 4/5 /Medical Due to (or as a consequence of) Examiner CAKOIO MUO DA THY Ischemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sicien and e burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed EMD Due to (or as a consequence of) Box 68760 Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Dav 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 3 Probably 4 donknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Hopatient 2 | EP/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler person who completed cause of death (Item 23a) (Type, Print) 11.0. 400 E. shore 31. Date filed (Months I 32. Registrar's Signature Year) 9 State 2004 THE VEN Registrar

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Tr. Father's Name (First, Mode, Last) Tr.	The state of teams (rest, Mode, Least) Jamie Lee Milliner 1sp. Informants hama Readsonship (Type, Prof) Jamie Lee Milliner 1sp. Informants hama Readsonship (Type, Prof) Jamie Lee Milliner 1sp. Informants hama Readsonship (Type, Prof) Jamie Lee Milliner 1sp. Informants hama Readsonship (Type, Prof) Jamie Lee Milliner 1sp. Informants hama Readsonship (Type, Prof) Jamie Lee Milliner 1sp. Informants hama Readsonship (Type, Prof) Jamie Lee Milliner 1sp. Informants hama Readsonship (Type, Prof) Jamie Lee Milliner 1sp. Informants hama Readsonship (Type, Prof) Jamie Lee Milliner 1sp. Informants hama Readsonship (Type, Prof) Jamie Lee Milliner 1sp. Informants hama Readsonship (Type, Prof) Jamie Lee Milliner 1sp. Informants hama Readsonship (Type, Prof) Jamie Lee Milliner 1sp. Informants hama Readsonship (Type, Prof) Jamie Lee Milliner 1sp. Informants hama Readsonship (Type, Prof) Jamie Lee Milliner 1sp. Informants hama Readsonship (Type, Prof) Jamie Lee Milliner 1sp. Informants hama Readsonship (Type, Prof) Jamie Lee Milliner 1sp. Informants hama Readsonship (Type, Prof) Jamie Lee Milliner 1sp. Informants hama Readsonship (Type, Prof) Jamie Lee Milliner 1sp. Informants hama Readsonship (Type, Prof) Jamie Lee Milliner 2sp. Informants hama Readsonship (Type, Prof) Jamie Lee Milliner 2sp. Informants hama Readsonship (Type, Prof) Jamie Lee Milliner 2sp. Informants hama Readsonship (Type, Prof) Jamie Lee Milliner 2sp. Informants Jamie Lee Milliner 2sp. Informants Jamie Lee Milliner 2sp. Informants Jamie Lee Milliner 2sp. Informants Jamie Lee Milliner 2sp. Informants Jamie Lee Milliner 2sp. Informants Jamie Lee Milliner Jamie Lee Milliner Jamie Lee Milliner Jamie Lee Milliner Jamie Lee Milliner Jamie Lee Milliner Jamie Lee Milliner Jamie Lee Milliner Jamie Lee Milliner Jamie Lee Milliner Jamie Lee Milliner Jamie Lee Milliner Jamie Lee Milliner Jamie Lee Milliner Jamie Lee Milliner Jamie Lee Milliner Jamie Lee Milliner Jamie Lee Milliner Jamie Lee Milline	C 48	ompleted	(Specify Elementary/Second	only highest grade	completed)	5+)	(Gi life	ve kind of w DO NOT	rork done	during most of w	rorking			s/Industry
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shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any sample immediate cause. Enter Underlying Cause (bread to mediate) Sequentially list conditions, any sample immediate cause. Enter Underlying Cause (bread to mediate) Sequentially list conditions, any sample immediate cause. Enter Underlying Cause (bread to mediate) Sequentially list conditions, any sample immediate cause. Enter Underlying Cause (bread to mediate) Sequentially list conditions, any sample immediate cause. Enter Underlying Cause (bread to mediate) Sequentially list conditions, any sample immediate cause. Enter Underlying Cause (bread to mediate) Sequentially list conditions, and sample immediate cause. Enter Underlying Cause (bread to mediate) If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 3 Probably 4 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown and the sequence of): 1 Yes 2 No 3 Probably 4 Unknown and the sequence of): 25. Was case referred to medical examiner? 1 Yes 2 No 3 Probably 4 Unknown and the sequence of): 25. Was case referred to medical examiner? 1 Yes 2 No 3 Probably 4 Unknown and the sequence of): 26. Place of Death (Check only one) Part II. Part of the sequence of the sequence of): 27. Manner of Death Part II. Part of the sequence of): 28. Divide the sequence of): 29. Divide the sequence of): 29. Divide to (or as a consequence of): 29. Divide to (or as a consequence of): 29. Divide to (or as a consequence of): 20. Divide to (or as a consequence of): 20. Divide to (or as a consequence of): 20. Divide to (or as a consequence of): 20. Divide to (or as a consequence of): 20. Divide to (or as a consequence of): 20. Divide to (or	stock or heart failure. List only one cause on each line. Indeed and peak deaded conditions of the peak of the pea	any in		21. Signature of Fund	eral Service License			J	POLION 10110W 103 Li	and Addrew Vay M Linden	leIson Fi Ave., I	ineral H Pocomoke	lome, Cit	P.A. y, MD 2	1851
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	+. Floyd E Gray 223 Phillip Moris U. Salisbury MD 21801	To 1	×	29b. Signature and ti	itle of certifier	13	γ		2	9c. Licens	Se number		29d. Da	3 / 1 8/	nin, Day, Year)

			For State Registrar	State of M	arylar	nd / Dep	oartmer e <i>rtificat</i>	t of H e of L	ealth a Death	and M	lental Hy	giene Reg. No. 2	004	12340
	Physici		1. Decedent's Name (First, Middle, Las Theodore Page								2. Date of D Month	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give 18 Brookside Rd	street and number)					Location o	of Death	March		200 unty of Deat orcest	h
	Funeral Director		233 40 4703	9x 7. Ag	70 (In yrs.	last birthda Yrs.	y) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D April	rth ay, Year) 13, 193	Co	nplace (State or Foreign untry) t Virginia
	Maryland i-f show	tor	Usual Residence of Decedent	er		ity, Town or cean F								10d. Inside City Limits 1 ☐ Yes 2 XNo
	or 288	Director	10e. Street and Number				10f. Zip					_	of What Co	untry?
36	72 hours after death with the Maryland natural', or items 23a or 28a-f show Jical Examiner must be natified at	by Funeral	18 Brookside Rd 11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? TYPes 2 If Yes, Give Year or Dates:	No E 3		3. Was Dece	cify Cuba	spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)		Race - Ame Black, White ecify: Whi	e, etc.
21215-0036	a within 72 hours jiene. r than "natural", ine Woolrel Ex	Completed I	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation		(Gil	edent's Usu ve kind of wo . DO NOT u	rk done d se retired	luring mosi)	t of worki	ng		of Business/I	ernment
Maryland 2	be filed stal Hygi ed other event, t	To Be Co	17. Father's Name (First, Middle, Last) Edward Moore	•					18. Mothe	e Ro	(First, Middle	e, Maiden Sui	mame)	
Mar	\$ 2 E E		19a. Informant's Name/Relationship (7 Stephanie A. Sul	•			-				i Route Numb	-		ip Code) ia 23832
Baltimore,	Pages 1 and 2 nent of Health a int: If item 27 Is iry or other tree		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Onation 5 Other (Specify	Removal from State		Place of Dis cemetery, cr	position (Nameral India) position (Nameral Ind	ne of ther place	e) 3	3-23-	ate	20c. Locati	ion - City or 1	Fown, State
Baltir	permit. Page Department Important: Il eny injury o		21. Signature of Funeral Service Licent		1002	- 11	22. Name ar	d Addres	s of Facilit	у	al Hom	108	Willian	Delaware n St., d. 21811
8760,	cate be executed / Medical physician and phy	dical Examiner	23a. Pafr1. Enter the disease of commondate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. Enter Underlying that initiated events resulting in death) Last	a. Due to (or as	a consecutive a consecutive	quence of):	nter the moo	e of dying	g, such as	cardiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	al death 3	□Ectopic pi □ Other (sp					23d.	. Date of delin	very Day Year
<u>α</u>	w requires that i been signed by should be deta	þ	Part II. Other significant conditions o	ontributing to death b	out not res	sulting in the	underlying o	ause give	n in Part I.			tobacco use o		the cause of death?
of Vital Records,		Completed	-11400-2								24a. Was auto perfe 1 🗆 Yes		prior to co death?	opsy findings available ompletion of cause of
Vit	Physician: this certifica ral director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpati	ent 2] ER/Outpati	ent 3□ DC	Othe			(Check only ne 5 X Res		Other (Spec	ih/)
	ding After fune		27. Manner of Death 1 Natural 5 ☐ Pending investigation	28a. Date of Inju (Month, Da		28b. Time Injury	of 2	8c. Injury Work	at	2	28d. Describe			
Division		Certification:	3 □ Suicide 6 □ Could not be 4 □ Homicide determined	28e. Place of In building, et	ury - At h c. <i>(Speci</i>	iome, farm, : fy)	street, factor	r, office		2		Street and Ni wn, State)	umber or Rui	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying Ph (Check only one)	ysicien: To the best liner: On the basis of and manner st	f examina	owledge, de ation and/or	ath occurred investigation	at the tim , in my op	e, date and inion, deat	d place, a th occurre	and due to the ed at the time,	cause(s) and date and pla	d manner as ce, and due	stated. to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier				290	. License				29d. Date si	gned (Month	, Day, Year)
1	-		30. Name and address of person who	completed cause of c	death (Ite	m 23a) (Typ	e, Print)		3156			5/22	107	
H	,7+1		31 Date filed (Month Day Year)	32. Régistr		2(8	Na	1	57	Sa	11:07	7 1	> 216	M
	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 3 2	004	ar s Sign	J.	parte	,						

				Type or Prin	nt in Black I aryland / De				-			
			1 - For State Registrar 1. Decedent's Name (First, Middle, La					Death	2. Date of D	Reg. No	7011	
}	Physici /Medi	cal	RAYMOND RULO 4a. Facility Name (If not institution, given	N MEARS		4b C	ity Town o	or Location of D	Month March			14 8:55 AM
	Examir Funeral	ier	Genesis ElderC 5. Social Security Number 6. S	are - The	e Pines		Ea der 1 Year	ston If Under 24	Hrs. 8 Date of B	irth	Talbo	
	Director		214-03-1466 Usual Residence of Decedent 10a. State 10b. County	89	Yrs.	<u> </u>			OCT.,	1912	MA	RYLAND
	e Maryla 8a-f shov	ctor	MD QUEEN AI	INE	CENTRE		E					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th with the 23e or 2	Funeral Director	10e. Street and Number 203 WHITEMARSH I	ROAD		10f.	Zip Code 21	617		_	izen of What C JSA	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any njury or other traumetic event, If a Modical Exactification to any njury or other traumetic event, If a Modical Exactification at ance.	þ	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent 8 Amped Forces? 1 A Yes 2 □ N If Yes, Give Year or Dates: 1	Ever in U.S. 13 to 1943-1945		s 2 X No	dispanic Origin an, Mexican, P Specify:	? (Specify Yes or N uerto Rican, etc.)	0-	14. Race - Am Black, Wh Specify:	
21215-0036	i within 72 ho jene. r than "natur II e Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		+) (Gi	edent's Use kind of NO	Isual Occup work done Tuse retire	oation during most of d)	working		ARBER S	
	I be filed ntal Hyg ed other: evant,	Be	17. Father's Name (First, Middle, Last)		СБЦ			Name (First, Middle			
, Maryland	and 2 shouk ealth and Me n 27 Is mark ear traumetic	10	19a. Informant's Name/Relationship (GLORIA ANN LEAGE)	• • •	R 162	PACA	WAY I	and Number o	r Rural Route Numb	er, City o		
Baltimore,	Pages 1 ment of He lant: If iter lury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special		20b. Place of Dis cemetery, co CHESTERF	rematory o	or other pla	ERY 3-	Date -30-2004		CREVILL	
Ball	Depart Import any in		21. Signature of Funeral Service Lice	Hellenher	F	ELLO	is, hei		N & NEWNA			OME, P.A.
	Physician /Medical Examiner	ılner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Due to (or as a	the death. Do not e							Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examin	that initiated events resulting in death) Last		a consequence of):	gone	raliz	ed				news
P.O. Box 6876	Attending Physician: The law requires that the death certificate by redeath cartificate by redeath. After this certificate has been signed by the attending physicistor. After this certificate has been signed by the attending physicisty the funeral director, page 2 should be detached for use as the business.	by Physiclan/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 1	2 Fetal death 3	I⊟Ectopic i⊟ Other	pregnancy (specify)	/			23d. Date of de Month	livery Day Year
ords, P.	w requires that been signed by should be deta	ted by Pr	Part II. Other significant conditions of Demantic	contributing to death bu	ut not resulting in the	underlyin	g cause giv	en in Part I.	1		se contribute t	o the cause of death?
Vital Records,	nysician: The law r nis certificate has be I director, page 2 sh	Completed							24a. Was auto perfo 1 🗆 Yes		24b. Were a prior to death?	utopsy findings available completion of cause of
Z.	ysicial is certif directo	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2 ☐ ER/Outpati	ent 3	DOA Oth		Death <i>(Check only</i> ig Home 5 ☐ Resi		G □Other (Spe	ocify)
Division of	Hospitel or Attending Ph. 24 hours after death. Funeral Director: After thi tely filled in by the funeral.	atlon: T	27. Manner of Death Natural 5 Pending 2 Accident investigatio		y 28b. Time Year) Injury		28c. Injur Wor 1 🗆		28d. Describe			
DİXİ		Certification:	3 Suicide 6 Could not be determined	building, etc					City or To	wn, State,)	ural Route Number,
		edical	29a. Certifier (Check only one) Certifying Properties 2 Medical Example 1	nysician: To the best of niner: On the basis of and manner stat	examination and/or	ath occurr investigati	ed at the tir ion, in my o	ne, date and pl pinion, death o	ace, and due to the ccurred at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	Georf us			29c. Licens	e number	933	29d. Date	3.25	h, Day, Year)
			30. Name and address of person who	LEY MD	508		EWIL	D Ave	SNUL /	IAS	Ton, M	10 21601
	Sta Registr	_	31. Date filed (Mo AR. 2916	OC 32. Tegistra	r's Signature	had	F 10				/	

			1 - State o	f Maryland / De	partment of learning of the control	Health and M Death		ene 2004	12342
	Physici /Medic		Decedent's Name (First, Middle, Last) WILLIAM GRANVILLE MARY	ÆL			2. Date of Death Month MARCH	Day Year 29 2004	3. Time of Death 2:10AM M
	Examin	-	4a. Fecility Name (If not institution, give street and nu TALBOT HOSPICE HOUSE	mber)	,	or Location of Death		4c. County of Death	
1	Funeral Director		5. Social Security Number 6. Sex 17. 16-7787 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last birthdi	Months Davs		8. Date of Birth (Month, Day, SEPT 9	9. Birth <i>Cou</i> 1915 MARY	place (State or Foreign ntry) 'LAND
	deeth with the Maryland rms 23a or 28a-f show	tor	Usual Residence of Decedent	10c. City, Town of	Location	-			10d. Inside City Limits M☐ Yes 2 ☐ No
	h with the	ai Director	10e. Street and Number 1 BELGRAVE CT.		10f. Zip Code 216	01	10	g. Citizen of What Cou USA	ntry?
	ges 1 and 2 should be filed within 72 hours after deeth with the Marylan it of Heatin and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28a-f show or other traumatic event, the Modical Examinar must be notified at	by Funerai		orces? 2X No	3. Was Decedent of II Yes, specify Cub	oan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
0-61717	s filed within 72 hours after dee I Hygiene. other then "natural", or frems ont, the Modical Examinating	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College ((G lift 1-4or 5+)	ecedent's Usual Occu ive kind of work done e. DO NOT use retire FARMER	during most of work	ing	6b. Kind of Business/Ir	
	nould be filed Mental Hyg narkad othan natic event,	To Be C	17. Father's Name (First, Middle, Last) WILLIAM SHREVE MARVEL			18. Mother's Name	e (First, Middle, M		
Mai	1 and 2 sho Health and iem 27 is mu		19a. Informant's Name/Relationship (Type, Print) MARION G. MARVEL/WIFE		BELGRAVE			City or Town, State, Zij 21601	o Code)
allimore	Pages 1 nent of He ant: If iten ary or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from '4 □ Donation 5 □ Other (Specify)	State cemetery, o	sposition (Name of crematory or other pla CEMETERY			OC. Location - City or To	
Dall	permit. Pages Department of Important: If i any injury or 2005.		21. Signature of Funeral Service Licensee	CEROP !	22. Name and Addr ELLOWS HAR		& NEWNAN BASTON, N	1 FUNERAL H	OME PA
, l	Physician		23a. Pert 1. Enter the disease, or complications that of shock, or heart failure. List only one cause on a limmediate Cause (Final disease or condition resulting in death)	aused the death. Do not				st,	Approximate Interval Between Onset and Death
Var	/Medical Examiner	ier	Sequentially list conditions, if any, leading to immediate Due to	(or as a consequence of): (or as a consequence of):					
,0070	cate be executed physicien and the burial-transit	dical Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C	(or as a consequence of):					
	The law requires that the death certific tie has been signed by the attending pl page 2 should be detached for use as t	Physician/Med	in the past 12 months?	ant at time of death	3 □Ectopic pregnanc 5 □ Other (specify) _	cy		23d. Date of delive	ery Day Year
cords, r.	equires that sen signed by lould be deta	by	Part II. Other significent conditions contributing to d	eath but not resulting in the	e underlying cause gr	ven in Part I.	23e. Did toba	acco se contribute to to	he cause of death?
	n: The law r icate has be r, page 2 sh	Completed	(erelianesculo	of J. W.	Afre	ery	24a. Was an autopsy perform	prior to co ed? death? No 1 Yes	opsy findings available mpletion of cause of
	To the Hospital or Attending Physician: The law within 24 hours after death, within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tion: To Be	27. Manner of Death 28a. Date	Inpatient 2 ER/Outpat of Injury th, Day Year) 28b. Time Injury	e of 28c. Inju			nce 6 Nther (Specif	HOSPICE
DIVISION	al or Atter after dea I Director d in by the	ertification:	3 Suicide 6 Could not be	of Injury - At home, farm, ng, etc. (Specify)	street, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura State)	Il Route Number,
	To the Mospital or within 24 hours after to the Funeral Dir. completely filled in a	Medical C	29a. Certifier 1 Certifying Physician: To the (Check only one) 2 Medical Examiner: On the b and man	best of my knowledge, de asis of examination and/or ner stated.	eath occurred at the transfer investigation, in my	me, date and place, opinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as s te and place, and due to	tated. o the cause(s)
	To the To the comp	M	29b. Signature and title of certifier	S) Janet	29c. Licen:	se number	290	d. Date signed (Month,	Pay, Year)
		li	30 Name and address of arson who completed cause	of seath (II on 23a) (Type	pe, Print)	Oxer St.	ENS	Jan mi	21601
	Sta Registr		31. Date filed (Month, Day, Year) 32. R	egistrar's Signature	29	7			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2 [] [] 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day CLYDE WILLIAM MCROY APRIL 3. 2004 10:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BOWIE HEALTH CARE CENTER BOWIE PRINCE GEORGES 5. Social Security Number If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Hours 81 396-14-0245 WISCÓNSIN Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director PRINCE GEORGES BOWIE 10e Street and Number 10f Zip Code 10g. Citizen of What Country? 3911 WAKEFIELD LANE 238 20715 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 (XYes 2 □ No If Yes, Give Year or Dates: "42-"45 or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within the and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) INTERNAL REVENUE AGENT FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JAMES HARRY MCROY AGNES DOROTHEA HAGSTROM 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is ury or other tra ELAINE LAURETTA McROY/ WIFE 3911 WAKEFIELD LANE BOWIE, MD 20715 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Macremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) HUNTT CREMATORY ortant: I WALDORF, MD 4/6/2004 Departr Imports any nju 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ROBERT E. EVANS FUNERAL HOME 16000 ANNAPOLIS ROAD BOWIE, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Candio respira /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last myocauleur Due to (or as a con Juence of) Examine be executed burial-transit and Due to (or as a consequence of): nding physician ause as the burial Box 68760 Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregnancy Jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen aper tension 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an has autopsy performed? Yes 2.24No 1 ☐ Yes of Vital To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DDA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 131602 30. Name and perso who completed cause of death (Item 23a) (Type, Print) Wearage Collanage Makelle, 31. Date filed (Month, Day, Year) 32. 8 gistrar's Signature State 5 2004 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 10 11.

			1 - For State Registrar	tate of Maryla		tificate of			neZUUI.	12344
	Physici /Medic		1. Decedent's Name (First, Middle, Last) FLORENCE MEYER					2. Date of Death Month APRIL	Day 200	3. Time of Death 4 7:00P M
	Examir		4a. Facility Name (If not institution, give stree FREDERICK MEMORI	AL HOSP		FREDER			4c. County of Dea	CK
	Funeral Director		5. Social Security Number 6. Sex 577-36-4717		rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y June 20,	^(ear) 1928 Was	thplace (State or Foreign ountry) hington, DC
	Maryland a-f show iffied at	ctor	10a. State 10b. County Maryland Frederick		City, Town or Lo Monrovia					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the 3a or 28a	I Direc	10e. Street and Number 12186 Overlook Lane	·		10f. Zip Code 21770		100	Citizen of What C	ountry?
336	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23s or 28s-f show event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 12.	Mas Decedent Ever in Armed Forces? I □ Yes 2 XNo If Yes, Give Year or Dates:			ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.
Maryland 21215-0036	filed within 72 hou Hygiene. Ather than "nature ant, the Mevical E	Completed	15. Decedent's Education (Specify only highest grade continuous Elementary/Secondary (0-12)	on mpleted) College (1-4or 5+)	(Give	tent's Usual Occupa kind of work done of OO NOT use retired Secretary	ation during most of work t)	ing	ib. Kind of Business	
nd 2	be filed ital Hygi id other event, I	Be	17. Father's Name (First, Middle, Last)	A 1		ceretary		e (First, Middle, Ma	iden Sumame)	ment
aryla	2 should be and Mental is marked o	L _O	John B. 19a. Informant's Name/Relationship (Type,	Aley	19b. Mailin	g Address (Street a	Elizabe		Iarshall City or Town, State,	Zip Code)
	ges 1 and 2 t of Health a if item 27 is		Carol Reed/ Daughter 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Remo	oval from State	cemetery, cren	natory or other plac	8)			
Baltimore,	permit. Pag Department Important: I any Injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Res	22		ss of Facility Sta	uffer Fur	rederick, neral Home erick, MD	e, PA
U	Pnysician		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one commendate Cause (Final disease or condition	ause on each line.	ath. Do not ente	er the mode of dyin	g, such as cardiac			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consi	equence of):	LATTON				2 MAYS
68760,	cate be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a conse	equence or _j .					
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Med	in the past 12 months?	f yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	ital death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
rds, P.	w requires that been signed t should be det:	by	Part It. Other significant conditions contrib METASTATIC CARC					23e. Did tobad		o the cause of death?
Vital Records,		Completed						24a. Was an autopsy performe 1 Yes 2	d? prior to death?	utopsy findings available completion of cause of 2 No
of	nding Physician: Th. th.: After this certifica funeral director, p	tlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 Ho 27. Manner of Ceath 1 Hatural 5 Pending 2 Accident investigation	ital: 1 Anpatient 2 8a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	4 Nursing Ho	n Check onl one me 5 ☐ Residenc 28d. Describe how	e 6 ⊡Other <i>(Spe</i> inŧury occurred	cify)
Division	To the Hospital or Attanding within 24 hours after death. To tha Funaral Director: After completely filled in by the fune	Certification;	a Could not be	8e. Place of Injury - At building, etc. (Spec	home, farm, stre	eet, factory, office		28f. Location (Stree City or Town, S	at and Number or Ru State)	ural Route Number,
	Hospi 24 hour Funar etely fill	edical	29a. Certifier Check only one) Certifying Physicia Certifying Phys	n: To the best of my ke On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the timestigation, in my op	e, date and place, sinion, death occurr	and due to the caus ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
)	To the within 2 To tha comple	Me	29b. Signature appriitle of certifier	and, M	۵		1761		Date signed (Monte	
	1		30. Name and address of person who complete BRYAN M, O CONNE	ated cause of death (Ite	em 23a) (Type, F 50/ W.	SEVENTH	ST.	CREDERIC,	KMD	21701
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature 4	loa	w. 1		,	

			For State Registrar	State of Ma	•	epartment of H Ce <i>rtificate of L</i>			ene 200L	12345
			Decedent's Name (First, Middle, La.	st)				2. Date of Death Month		3. Time of Death
	Physicia /Medic		Richard	W.		Marine, Sr	•	MARCH	31 20	040735M
	Examin		4a. Facility Name (If not institution, give	1 111		4b. City, Town or	Location of Death		4c. County of Dea	
			5. Social Security Number 6. S	na Medi	(In yrs. last birth	day) If Under 1 Year	If Under 24/Hrs.	8. Date of Birth		
	Funeral Director			M 2□F	64 Y	Months Davs	Hours Min.	(Month, Day, 1		thplace (State or Foreign ountry)
	ъ		Usuel Residence of Decedent							
	arylar show	١	10a. State 10b. County MD Wicom:		10c. City, Town			*		10d. Inside City Limits 1 Yes 2 No
	the M.	ecto	MD Wicom:	Leo	Salis	10f. Zip Code		10	g. Citizen of What C	
	with With Lear	2		Desires		2180	/1		USA	ourity.
	death ms 2;	Funeral Director	4833 Meadow Lark 11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Decedent of Hi		cify Yes or No-	14. Race - Am	
2	or Ite	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ▼ N	•	1 ☐ Yes 2 No	Specify:	nican, etc.)	Black, Wh	te, etc.
3	should be filed within 72 hours after death with the Maryland did Mental Hygiene. The Willes 23a or 28e-1 show marked other then "netural" or Items 23a or 28e-1 show marked other then "earning ruust te rutilied at unatte event, the Medical Examina ruust te rutilied at	d by	3 □Widowed 4 □Divorced	If Yes, Give Year or Dates:					V	Thite
ò	in 72	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		Decedent's Usual Occupa Give kind of work done d life. DO NOT use retired,	ition Juring most of worki)	ng "	6b. Kind of Busines:	vindustry
7	iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5-	-)	alesman			Boat	
2	e filec al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Mi	aiden Sumame)	
Z Z	Menta Menta Brked	10	Robert Willis Mar	ine				Ellen Ma		
2	2 sho and is m		19a. Informant's Name/Relationship (Mailing Address (Street a			-	
ב ע	1 and Health em 27 ther t		Sandra Lee Marine 20a. Method of Disposition	/Wife	20b. Place of D	3 Meadow La Disposition (Name of	: D		oc. Location - City o	
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healin and Mental Hygiene. Department of Healin and Mental Hygiene. Department of Healin and Mental Hygiene. Department of Healin and Mental Hygiene. Department of Hygie		1 Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif		cemetery,	crematory or other place Hill Cemete	1			
allillo	nit. P vartme oortan injur		1. Signature of Funeral Service Liver		Laurel	22. Name and Addres Hinman Fur			iurer, De	Laware
Ď	Per Dep Per Per Per Per Per Per Per Per Per Per	1	MIRRO XXXX	ManyMo	0295	11673 Some	eral home	., Prince	ess Anne,	MD 21853
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each line	the death. Do no					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. My	ocardia	Inta	rolin			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):				
		ē	Sequentially list conditions, if any, leading to immediate	b	consequence of):				
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events							
Ď	an an an irial-tr	Exa	resulting in death) Last	Due to (or as a	consequence of):				
0/00	ficate be executed physician and ts the buriat-transit	licai		d						
		/Medi	IF FEMALE:	23c. If yes, outcome of	of pregnancy				22d Data of da	linear
Š	The law requires that the death certi ale has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	1□Live birth 2	Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of de Month	Day Year
į	t the d by the ached	hysi	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unknown						
v,	ss that gned l	by P	Part II. Other significant conditions of	ontributing to death bu	t not resulting in t	he underlying cause give	en in Part I.	23e. Did toba	icco use contribute t	o the cause of death?
corus	equire							1 Yes	2 □ No 3 □ P	robably 4 Unknown
ည်	law r	Completed						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
<u> </u>	: The							perform 1 Yes 2	No 1 □ Ye	2 □ No
=	sicier certif irecto	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatier	* 2 D CD/Outs	atient 3 DOA Othe	26. Place of Death		ce 6 □Other (Spe	no.if.il
5	g Phy er this	n: To	27. Manner of Death	28a. Date of Injun (Month, Day	/ 28b. Tie	ne of 28c. Injury	at 2	28d. Describe how		(
VISION	ath. r: Afte	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	1	7647/ 111)		res 2 □No			
<u>2</u>	or Atte	ertification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined			n, street, factory, office		28f. Location (Stre City or Town,	et and Number or F State)	ural Route Number,
ב	pitel c	O	One Continue 180 Continue Di	usician: To the best o	f my knowledge	double convered at the time	o date and place of	and due to the ear	cools) and manners	o stated
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier (Check only one) Certifying Properties (Check only one)	niner: On the basis of and manner sta	examination and	death occurred at the tim or investigation, in my op	pinion, death occurre	ed at the time, dat	e and place, and du	s stated. e to the cause(s)
	Fo the Mithin Fo the comple	Me	29b. Signature and title of certifier	0		29c, License	_		d. Date signed (Mon	
	, ,, ,		Mare Wi	un MT		7	41813		3/31/04	
			30. Name and address of person who	completed cause of de	ath (Item 23a) (T		A 01	choss. 1	7	1801
			31. Date filed (Month, Day, Year)	AN NID	r's Signature	BIU	1" Jan	Spay 1.	1) 1	00/
	Sta Registr			3 2004	we K	hole				

200	S POIGE	,	1 - For State Registrar	State of I	Marylar	•	artmen rtificate			nd Me		jiene Jeg. No. <i>(</i>	20n	1	12316
	Physici	an	1. Decedent's Name (First, Middle, Las		abis						2. Date of Dea Month MARCH	Day	Yea 2004	ır	Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give 524 N. CHARLES S		er) PT #	412			Location of				ounty of De	_	1000 1
	Funeral Director		21/32-30/0	x 7. XM 2□F	Age (In yrs. 74	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Jan. 29	, Year)		Birthpleca Country) I thu	a (State or Foreign an i a
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland		10c. Ci	ty, Town or Lo		altin	more						Inside City Limits 1 Yes 2 □ No
	with the	Director	10e. Street and Number 524 N.Charles	St. Ant	<u>412</u>		10f. Zip	Code 21:	201			l 0g. Citize	U.S.	-	?
980	72 hours after death with the Maryland natural; or Hems 23a or 28a-f show Steal Examinal must be notified at	by Funeral	11. Marital Status **Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	ent Ever in Ues? XNo	J.S. 13.	Was Deced If Yes, spec	lent of Hi		in? (Spec Puerto P	cify Yes or No- lican, etc.)		Race - A Black, W	merican	
21215-0036	c • 3	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12		or 5+)	(Give	dent's Usua kind of wor DO NOT us	rk done d se retired,	lu <i>ring m</i> ost	of workin	g		of Busine		,
Maryland 2	2 should be filed within and Mental Hygiene. is marked other then sumatic event, the M	To Be C	17. Father's Name (First, Middle, Last) KazimierasP.		i		•		18. Mother	Herta	(First, Middle, a Lange	Maiden S	umame)		
	27 let		19a. Informant's Name/Relationship (7 John Galinaitis/						nd Number re St		Route Number Taneyt	-			de)
Baltimore,	Pages 1 and 2 ent of Health nt: If item 27 in y or other tri		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		ate	Place of Dispo cometery, crei	matory or o	ther place		Da /2/20	004		tion - City		
Balti	permit. Pages. Department of himportant: If ite any injury or of once.		21. Signature of Funeral Service Licental Marine). Xlav	bar	/ 22	2. Name an 310 Cl	d Addres	s of Facility	Hart New	zler F	unera	1 Hor	ne	
B STORY MAN	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or composition shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. A then Due to (or	as a conse	quence of):			y, such as c			est,		Int	proximate erval Between eset and Death
8760,	ate be executed hysician and the burial-transit	Ical Examine	Cause (Disease or injury that initiated events resulting in death) Last	c	as a consec	quence of):									
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outco 1 □ Live birti 4 □ Pregnan 9 □ Unknow	n 2 ∏Feta It at time of a	al death 3	□Ectopic pr □ Other (sp					23	d. Date of o	delivery Day	y Year
rds, P.	quires that on signed to uld be deta	by	Part II. Dther significent conditions of Chronic acco	ontributing to deal	th but not re	sulting in the u	inderlying ca	ause give	en in Part I.			bacco use es 2 🗆		to the c	ause of death?
al Records,		Completed										med? 2 \(\text{No} \)	24b. Were prior I death 1 X Y	o comple	findings available etion of cause of No
f Vital	dis ys	To Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inp	atient 2] ER/Outpatier	nt 3 DO	A Othe			(Check only or e 5 ☐ Resid		⊅ Other (S	pecify) Î	AT SCENE
ion of	fing After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		Injury <i>Day</i> Yea <i>r)</i>	28b. Time o Injury	f 2	8c. Injury Work	at :? ∕es 2 ∐ N	- 1	8d. Describe h	ow injury (occurred		
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of	Injury - At h , etc. <i>(S</i> p <i>ec</i>	nome, farm, sti ify)	reet, factory	r, office	12 3 May 2	2	8f. Location (S City or Town	treet and i n, State)	Number or	Rural Ro	oute Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exan		is of examin										
	To the comple	Me	29b. Signature and title of certifier	mis			290	: License			2	9d. Date	signed (Ma	onth, Day	
	My		30. Name and address of person who	completed cause	of death (Ite			reet	, Bal	.timo	re, Mar	ylan	d 212	01	
	Sta Regist		31. Date filed (Month, Day, Year) MAR 3 1	32. Reg	istar's Sign	ature			-			-			

ORIGINAL

		ricase i	State of Mandan	d / Donortm	ont of Health and	Mental Hygie	ine	
		1 _ For	State of Marylan	u / Departini	ent of Health and ate of Death	Mentarriygie	2004 1231	, 7
		Registrar		Certific	ale of Dealif	Reg.	No. 3. Time of Death	7 /
Physic	ian	Decedent's Name (First, Middle, Last)				Month	Day Year	
/Med		Elizabeth				-	7:30 am	
Exam	iner	4a. Facility Name (If not institution, give st	treet and number)	4b. C	lity, Town, or Location of Dea	th	4c. County of Death	
		Union Hosp			Elkton nder 1 Year If Under 24 Hrs	S O D-4(Dimb	Cecil	
Funera		5. Social Security Number 6. Sex	M X F 7. Age (In yrs. I	Mont		. (Month, Day, Ye		ign
Directo		173-22-6197		74 Yrs.		December	15, 1929 PA	
Pu ≱		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Location			10d. Inside City Limi	ts
lanylan show	5		170	11=+ on			1 ☐ Yes 2 ∜☐ N	No
he N	Director	MD Cecil 10e. Street and Number	E.	1kton	. Zip Code	10a	. Citizen of What Country?	
il Z 13-0030 within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show to M. disal Examinar must be notified at	급		G1 D.1					
s 23	Funeral	515 W. Lewis	2. Was Decedent Ever in U.		21921	Specify Yes or No-	U.S.A. 14. Race - American Indian,	
er de Rem	Ë	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 No	If Yes,	ecedent of Hispanic Origin? (specify Cuban, Mexican, Pue	rto Rican, etc.)	Black, White, etc.	
rs aft	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Ye	s 20 No Specify:		Specify: White	
Pour Pour		15. Decedent's Educ	ation	16a. Decedent's	Jsual Occupation	16	b. Kind of Business/Industry	
in 72	Completed	(Specify only highest grade	completed)	(Give kind o	f work done during most of wo T use retired)	orking		
with ene.	E	Elementary/Secondary (0-12) 1 2	College (1-4or 5+)	Hous	ewife		Household	
be filed within tal Hygiene. Ind other than event, the M		17. Father's Name (First, Middle, Last)				me (First, Middle, Ma		
yidili buid be Mental arked o	To Be	Philip Boyd			Mary F	Raytor		
laryiar 2 should be and Menta is marked aumatic ex	1	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailing Add			City or Town, State, Zip Code)	
Mar d 2 s th ar trau		Kevin Madden/S	lon	515 W.	Lewis Shore	Pd . F1	kton, MD 21921	
ore, Maryle s 1 and 2 should of Health and Men item 27 is marke other traumatic		20a. Method of Disposition	20b. P	lace of Disposition	(Name of		c. Location - City or Town, State	
permit. Pages Department of temportant; if its any injury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	emetery, crematory		10 000	4 711-1 100	
it. P.		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune (Specify)			netery April e and Address of Facility	12, 200	4 Elkton, MD	_
Dalltimo		The same of the sa		Andr	ew G. Gee	259	E. Main Street	
4024		23a. Part1. Enter the disease, or complice shock, or leart failure. List only on	nations that caused the deat	Pune Fune	ral Home	Ar respirator	ton, MD A22221	
		shock, or leart failure. List only on	e cause on each line.	iii bo not ontor the	,	, , , , , , , , , , , , , , , , , , , ,	Interval Between Onset and Death	
Physicia		Immediate Cause (Final disease or condition resulting in death)		ulmonar	y arrest			
/Medica Examine		resulting in dealiny	Due to (or as a conseq	uence of):				
LAGIIIII		Sequentially list conditions, b	Due to (or as a conseq	hec	nt orater i			
be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Old to (or as a conseq	derice or).				
ecution and ruran	кап	that initiated events c	Due to (or as a conseq	uence of):				
If bU , the be executed sysician and ne burial-transit	Ē		la colo	_ i				
BOX 68/re leath certificate b attending physic	dicai	_ d	. MOOL OK	acci pr	essure	.		
Geath certificate attending physical for use as the	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregna	2001			22d Pate of delivers	
BOX eath cer attendir for use	an	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta	il death 3 □Ectop	ic pregnancy		23d. Date of delivery Month Day Year	
the de. by the a	/sic	1 ☐ Yes 2 No 9 ☐ Unknown	4☐Pregnant at time of d 9☐Unknown	ieath 5 Othe	r (specify)			
	P.	Part II. Other significant conditions con	stributing to death but not res	ulting in the underly	ng cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?	
Hecords, P The law requires that are has been signed b	Ď	COPI		,		1 ☐ Yes	2 No 3 Probably 4 □Unknow	₩n
Orc requi	Completed	COVD	2					
law law as b) dc	High bloc	d presou	re		24a. Was an autopsy	24b. Were autopsy findings availal prior to completion of cause of death?	of
	등	Toppess	abuse			performe 1 ☐ Yes 2	No 1 Yes 2 No	
VITAI HECOTGS, eicien: The law requires t certificate has been signs irector, page 2 should be.	Be (25. Was case referred to medical examiner?				eath (Check only one)		
Of V Phyeic this ce	ဥ	1 ☐ Yes 2X No		ER/Outpatient 3			ce 6 □Other (Specify)	
On O ding Pi h. After th		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred	
DIVISION OF I or Attending Phy after death. Director: After this d in by the funeral d	atic	2 Accident investigation		М	1 ☐ Yes 2 ☐ No			
DIVISIO Il or Attend after death Director:	tif	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fa fy)	ctory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)	
tal o	Certification:							
ospi hou uner uner	cai	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examil	sician: To the best of my kno ner: On the basis of examina	owledge, death occu ation and/or investiga	rred at the time, date and place at the time, date and place ation, in my opinion, death occ	ce, and due to the caus curred at the time, date	se(s) and manner as stated. a and place, and due to the cause(s)	
Division of Vita With the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	one)	and manner stated.				. Date signed (Month, Day, Year)	
- c - E	- ≥	29b. Signature and title of certifier	\		29c. License number	290	4 8 10 4	
0 1 € 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						_	LVIII I VLL	
J W T		Obboyeon	mb.		Decree 15			
2 2		30. Name and address of person who co	\		DCCCC 12.			\sim
3		30. Name and address of person who co	\	omic	223 W V		ect, Elktonin	0

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		State of Maryland / Department of Health and M Certificate of Death		0001	10010
		Decedent's Name (First, Middle, Last)	2. Date of Death	No. 2	3. Time of Death
	Physician /Medical	Lena Frances Moody 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Lo	March	24, 200 4c. County of Dea	
	Examiner	4b. City, Town, or Lo Bradford Oaks Nursing Facility Clinto		Prince	
	Funeral Director		8. Date of Birth Month Day, Ye 9 - 20 - 1		thplace (State or Foreign
	pue *	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Maryler of ahow	MD Montgomery Silver Spring			12 Yes 2□ No
	th with the M 23a or 28a-f at Le mutt ai Directo	10e. Street end Number 10f. Zip Code 20906		Citizen of What Co	-
020	thin 72 hours efter death with the Marylend en "natural", or items 23a or 28a-f show Medical Examiner must be incited at hipleted by Funeral Director	11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerto III □ Yes X 2 □ № Year or Detes:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
Maryland 21215-0020	led within 72 ho lygiene. Nr. tre Medical Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16e. Decedent's Usual Occupation (Give kind of work done during most of working the properties) Iffe. DO NOT use retired) Homemaker	ng 16b	Kind of Business Domesti	-
2	be filed tal Hygin d other event, to	17. Fether's Neme (First, Middle, Last) 18. Mother's Name	(First, Middle, Maid	den Surname)	
Var	should be and Mental marked imatic ev	George Smith Anna	Blair		
Man	and 2 sho alth end 1 27 is me or traume	19a. Informent's Name/Relationship (Type, Print) Robert M. Moody - Son 19b. Mailing Address (Street and Number or Rural 19c. Mailing Address (Street and Number or Rural 19c. Mailing Address (Street and Number or Rural			
Baltimore.	Peges 1 end nent of Health int: If Item 27 iry or other tr	20a. Method of Disposition The Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Arlington Cemetery 4		Location - City or rlingto	Town, State n, Virgini
Balt	permit. Depertment imports any injure.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Blount Funeral			gia Ave.NW n, DC 2001
		23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.	r respiratory arrest,		Approximate Interval Between Onset and Death
	Physician //viedicar Examiner	Immediate Cause (Final disease or condition resulting in death) e. Due to (or as a consequence of):	rugu	7	WESKS
	executed in end iel-transit	b .		 	
68760.	ficete be executed the sphysician end is the buriel-transit edical Examin	Sequentially list conditions, if erry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as e consequence of):			
Box 687		resulting in death) Lest Due to (or as e consequence of):		1	
	death death death	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobac	co use contribute	to the cause of death?
P.0	ss that the death cert gned by the ettendim be deteched for use by Physician/M	ATHENO Sclero sir	1 Tyes		robably 4 Unknown
Division of Vital Records.	The law requires that the death certicate has been signed by the ettending page 2 should be deteched for use completed by Physician/M		24a. Was an au performed	?	Were autopsy findings available prior to completion of cause of death?
8	The land sets he page		†∐ Yas	XXNo	1 □ Yes 2 □ No
Vita	Physician: The this certificate rel director, pag.: To Be Co.:	25. Was case referred to medical examiner? Hospital: Character of Death Other: Character of Dea		100	
on of	ding Physic h. After this ca funerel dire	27. Menner of Deeth 1 Deet of Injury (Month, Dey Year) 1 Deet of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 1 Deet of Injury	ne 5 🗌 Residence 28d. Describe how in		cify)
Divisi	To the Hospital or Attending P within 24 hours eiter death. To the Funeral Director: Aftert completely filled in by the funeral Medical Certification:	CD Could get be	8f. Location (Street City or Town, St	an <i>d Number or R</i> u ete)	rel Route Number,
	Hospitu 24 hours Funera Illetely fille	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, e consideration and/or investigation, in my opinion, death occurred end maximer stated.			
	To the comp	29b. Signature end title of certifier 29c. License number	3/7	Date signed (Monti	
)	6	30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)	103 75	Walha	To Mi)
	State Registrar	31. Dete filed (Month, Day, Year) APR 0 1 2004 Line April 1 2004	, , , ,		0119

DHMH 16 Rev 6/95

		•	For State Registrar	State of Maryland		rtment of He			ene g. No. 200	L 1231.9
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Naomi Carter	Mitchell				2. Date of Death Month March 2	Day 2004	3. Time of Death 8:20 am
*	Examin	er	4a. Facility Name (If not institution, give to 6409 Bushey Driv	e		4b. City, Town, or Temple 1			4c. County of De	eorge
£	Funeral Director		5. Social Security Number 577-20-5831 Usual Residence of Decedent	7. Age (In yrs. Ia M 2XCXF 84	St birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Dey, Jan. 17,	Year)	tirthplace (State or Foreign Country) shington,DC
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow any injury or other traumatic event, the Medical Evant are must be inclified at once.	Director	DC 10b. County DC 10b. Street and Number 4252 Brooks Stre	Was	hingto			10	ng. Citizen of What	•
036	ours after death ral', or Iteme 23	by Funeral		12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates:	l II	Vas Decedent of His Yes, specify Cuban	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Al Black, W	merican Indian,
Baltimore, Maryland 21215-0036	ed within 72 ho giene. er than "natur t, the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th	cation e completed) College (1-4or 5+)	(Give I		uring most of work	ing	6b. Kind of Busine Governme	
yland	ould be fill Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) Albert G. Carte				Margare		own	
, Mar	and 2 sh ealth and m 27 is m		19a. Informant's Name/Relationship (Ty Maja T. Rasheed/Aka Mars	ha T. Parker	6409	Bushey Di	r. Temple	e Hills,	Md. 2074	8
imore	Pages 1 ment of H tent: If Ite		20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)	Ar1	ingtor	sition (Name of natory or other place n Nat'l Ce	em. Apr.	9,2004 A	oc. Location - City	Virginia
Bail	Depart Depart Import eny in		21. Signature of Funeral Service Licens Watte K.	1000	Å ² 55	Name and Address Lexander 3 38 Marlbo	S.Pope Fi oro Pike	uneral Ho Forestvi	ome 11e,Md.	20747
2	Physician /Medical		23a. Part1. Inter the disease, or complete shock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	cause on each line. Due lo (or as a conseque	ve 1	Heart	such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
8760,	death certificate be executed to a stending physician and and indict use as the burial-transit.	Ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence. Due to (or as a consequence.						
P.O. Box 68	that the death certifica hed by the attending pt detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 ∐Live birth 2 ∭Fetal of 4 ∰Pregnant at time of dea	déath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of o Month	lelivery Day Year
	The law requires that the ate has been signed by th page 2 should be detache	by	Part II. Other significent conditions co	ntributing to death but not resul	ting in the ur	nderlying cause give	n in Part I.			to the cause of death? Probably 4 □Unknown
al Reco	n: The law r ficate has be or, page 2 sh	e Completed	25. Was case referred to medical				00 81		prior t death No 1 \(\sum Y\)	
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		R/Outpatien 28b. Time of Injury	t 3 DOA Other	r. 4 Nursing Ho	th (Check only one ome 5 - Resider 28d. Describe how	nce 6 K lOther (S	Daughter's PecifyResidence
Divis	ital or Att us after de rel Direct	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)				City or Town,	State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funerel Completely filled	Medical	29a. Certifier (Check only one) 1 ⚠ Certifying Phy 2 ☐ Medical Exami	sician: To the best of my knowner: On the basis of examinational manner stated.	rledge, death on and/or inv	restigation, in my opi	inion, death occur	red at the time, da	use(s) and manner te and place, and d d. Date signed (Mo	ue to the cause(s)
)	- M - 8		rafler Not	Jes'		115				-04 NETII 20017
)	- (4)		30. Name and address of person who could be a series of person who could be a series of the series o	MOTAZ	ED.	I, MY	\ \ \doldo\	ashing	ton, Dici	20019
Di	Regist	rar	MAR 3 0 2004	2. Registrar's Signatu	Span	W				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2004 Mary Marc /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Manor Care Health Services Largo, Hours Min. 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 F 578-34-1515 Yrs. Director Aug. 25, 1916 Tompkinsville, MD Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location od 2 should be filed within 72 hours after death with the Marylan thit and Mental Hygiene. 27 Is marked other than "netural; or items 23s or 28s-1 show treumatic event, the Middles Examine must be nutilised as 1 X Yes 2 □ No Director Capitol Heights Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number # 406 20743 United States 1207 Addison Road Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. l □Yes 2□No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes X No Specify: Baltimore, Maryland 21215-0036 Specify: Completed by 3 ₩ Widowed 4 Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 8 Laboratory Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Walter Hill Mary Magdeline Swan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bowie, Maryland item 27 l Jacqueline Haselrig / Niece 408 Jaystone Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Lincoln Memorial Cem. 4/3/2004 Suitland, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Alexander S. Pope Funeral Homes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Multisysten Immediate Cause (Final tailure 1 moute **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** carcinout DUZast Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed dewnivos resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) signed by the al d be detached for 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 TYes 3 Probably 4 Unknown should I 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 5 Pending investigation 1 Natural 1 □ Yes 2 □ No death. Director; 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tirle of certifier 420 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maxlboro Pk. Upper Marlboro, MD all 6. Champaloup MD. 31. Date filed (Month, Day, MAR 2 9 2004 Registrar

DHMH 17 Rev 1/2001

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	1	Registrar Decedent's Name (First, Middle,	(ast)	Ce	rtificate of D	eath	2. Date of De	Reg. No.	2004	The Contract of the Contract o
Physician			David Miller				Month	Day	Yeer	3. Time of Deat
/Medical		a. Fecility Name (If not institution,			4b. City, Town, or L	continue of Death	March			5:07 A
Examiner		1519 Birchwood							County of Deeti	
uneral	5.			rs. last birthday,	Oxon H	IT LLL If Under 24 Hrs.	8 Date of Birt		rince (
irector		247-70-4380 Usual Residence of Decedent	. XX	O Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day Novembe	y, Year)l er 11	943 Sou	nplace (State or For untry) ith Carol
uffind at	- 1	0a. State 10b. County Maryland Princ	e Georges	City, Town or Li	n Hill					10d. Inside City Lir 1 XYes 2 ☐
23a or 28a-1 all the notified	1	0e. Street and Number 1519 Birchwood	Drive		10f. Zip Code 20745	,			en of What Cou	•
yearthen *natural; or ltems 23a or 28s-1 ehov it, the Medical Examinar must be notified at Completed by Funeral Director	1	1. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:		Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 No	panic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		4. Race - Amer Black, White Specify: B1	, etc.
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arked o atic eve To Be		Jimmy Mill	.er			Phobe	Frie	rson		
Item 27 is market other traumatic		9a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street and	d Number or Run	al Route Numbe	r, City or 1	Town, State, Zi	p Code)
tem 27 i	1	Pearl Salmon Ray	-Miller (Wife)	1519	Birchwood	Drive;0	xon Hil	1,Mai	ryland	20745
돌등	20	Oa. Method of Disposition	206	. Place of Dispo	sition (Name of natory or other place)		Date	20c. Loca	ation - City or T	
in o		1 X Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spe			coln Cemet	Marci	27,200	4 Brent	twood.	Maryland
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		SHOCK, OF HEART FAILURE. LIST OF	ly one cause on each line.	eath. Do not ent	er the mode of dying,	such as cardiac o	or respiratory arr	est,	8-0-1	Approximate Interval Between
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			For State Registrar	,		rtificate of			eg. No. 2001	12352
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day Year	3. Time of Death
	/Medic	al	Marie H Marshal			at o't Tour		MARCH	23 200	
2	Examin	er	4a. Facility Name (If not institution, give s				or Location of Dea	ıtn	4c. County of De	
	Funeral		Doctors Communi 5. Social Security Number 6. Sex			Lanhai	If Under 24 Hr		Prince 9.B	rthplace (State or Foreign Country)
	Director		579-54-9403	M 2₽F	Yrs.	Months Days	Hours Min	3-14-3	1	hington DC
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Lo	veation				10d. Inside City Limits
	Aaryla f sho	៦	Md Prince G			ington				1 Yes 2 No
	the 28a-	Director	10e. Street and Number	,corgo ic	Wasii.	10f. Zip Code		1	Og. Citizen of What C	1
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36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☑ No				Black
0	be filed within 72 hours after death with the Marylan half Hygiene. Id other than "naturel", or itema 23a or 28a-f show other than "naturel", or itema 23a or 28a-f show event, the Medical Example or must be notified at	ed b	15. Decedent's Educ	Year or Dates:	16a. Dece	dent's Usual Occup	pation		16b. Kind of Busines	
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Baltimore,	permit. Pages 'Department of h Importent: If ite any injury or ot		1 Surial 2 Cremation 3 □R 1 Donation 5 Other (Specify)	emoval nom State	urre			7-04	Clinton 1	Maryland
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Box	death d for i	Physician/M	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de		Ectopic pregnancy Other (specify) _	У		Month	Day Year
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Division	or Attendate death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,		eet, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	lural Route Number,
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	To the Hospitel or Attu- within 24 hours after de To the Funeral Diracto completely filled in by th	edicai	(Check only one)	sician: To the best of my know ner: On the basis of examinati and manner stated.	ion and/or in	vestigation, in my o	ne, cate and plac ppinion, death occ	urred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	1,		29c. Licens	se number	2	9d. Date signed (Mon	th, Day, Year)
/			larand All	ai, di		Doos	8275		3-23-0	4
1	(0)		30. Name and address of person who co						,	
			PARAND ALAVI, MI 31. Date filed (Month, Day, Year)		LUCK Y	ROAD LA	NHAM, MI	20706		
	Sta Registi		MAR 2 9 2004	32. Registrar's Signat	book	2				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yee MARCH **Physician** MOORE 11:45 AM GLEN 2004 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE d Agnes Healthrare If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) June 28, 1954 i. Social Security Number 239–92–9194 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 49 Hours Yrs. Director Jackson, Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location Baltimore 10d. Inside City Limits or itema 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Director 10e. Street and Number 2950 Carver Rd. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 USA Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23s sny injury or other traumatic event, the Madical Example 1. use 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 Married 1□ Yes 💹 No Maryland 21215-0036 Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Moore Raymond Ethel Mae Simmons 19a. Informant's Name/Relationship (Type, Print) Leon Moore, Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 134 Seaboard, NC. 27876 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State 03/27/04 Jackson, NC. Hill Chapel Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bianchi F.S. 814 Upshur St. NW, Washington, DC 20011 crestion 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IMMUNYO DEFICIENCY SYMDROME **Physician** ACQUIREL UKKHOWA /Medical Due to (or as a consequence of): Examiner INFECTION MHKHOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of). Box 68760. Completed by Physiclan/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? detached for Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. the 9 Unknown 9 Unknown à signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖄 Unknown Should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 No of Vital Physician: 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 2 Inpatient 2 ER/Outpatient 3 DOA Sign in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division To the Hospital or Attending 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No s after death death 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) ma 100 60 (05 MARCH housan 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUENLUS BALTIMORE · UM 900 CATOH HERSOK WA 31. Date filed (Month, Day, Year)
MAR 2 9 2004 32. Registrar's Signaturé State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) March **Physician** 2004 2:30 AM Catalina Molina /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Nursing Facility Montgomery Rockville If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Puerto Rico 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗓 F 125-09-9051 Director 88 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County *how the Medical Examiner must be notified at 1 XYes 2 No Funeral Directo MDAnne Arundel Crofton 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 23a 2312 Dartmouth Lane 21114 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or Items 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Puerto Maryland 21215-0036 1XXYes 2□No þ Specify: 3 □Widowed 4 □ Divorced Rican White 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 is marked other the eny injury or other traumatic event, Ina QDCE. 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Juana Maldonado Baldomero Molina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sarita Byas / daughter 2312 Dartmouth Ln. Crofton, MD. 21114 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 3-29-1 Burial 2 Cremation 3 Removal from State Lakemont Mem. Gardens 2004 Davidsonville, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee Bowie, MD. 6512 NW Crain Hwy. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MnoxIC encophalopalny /Medical Due to (or as a consequence of): Examiner As Dication Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physicien as the burial-1 Box 68760. Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 10 has B 2 certificate ha 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Colorsing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 ☑ No 3 DOA 27. Manner 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Medicai Certification: 1 Tatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8607 2nd Ave lahryar Davar IND 31. Date filed (Month, Jay, Year) 32. Registrar's Signature State MAR 2 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 7:00 p M W. MUNFORD MARCH 23, 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES HOSPITAL CENTER CHEVERLY PRINCE GEORGES If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F 49 Yrs. 212-66-4567 Director Nov. 24. D. C. Usual Residence of Decedent with the Maryland r 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Md. Prince Georges Landover 1X Yes 2 □ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 급 ō ral', or Items 23a o 7910 Allendale Drive 20785 U. S. A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural; or Ite ury or other traumatic event, III Mental Earus. ury or other traumatic event, III Mental III Earus. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hospital Elementary/Secondary (0-12) College (1-4or 5+) Clerk 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie Palmore Betty Gamble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Landover, Md. 20785 Betty A. Hairston (Mother) 7910 Allendale Dr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of H
Important: If its
any injury or ol 1 ■ Burial 2 □ Cremation 3 □ Removal from State Harmony Memorial Park 04-01-04 Landover, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility W. H. Bacon Funeral Home, 21. Signature of Funeral Service Licenses Vanda 3447 14th ST., N.W. Washington, DC 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not end the mode of dying, such as carding or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day Month Year signed by the at d be detached for 4☐Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by should be 1 ☐ Yes 2 ☐ No 3 Probably Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate 1 ☐ Yes of Vital To the Hospital or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ZO No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA hin 24 hours after death.

the Funeral Director: After thin phletely filled in by the funeral 27. Manner of Death 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred Division Natural 5 Pending investigation Injury ∕2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral (1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of 29c. License numbe certifie 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Dr., Cheverly, Md. James Catevenis, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 9 2004 Registrar

		•	1 - For State Registrar	State	of Marylan	•	artmen rtificate			and M	-	jiene eg. No.20	04	12356
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	/Medic	al	Gertrude 4a. Facility Name (If not institution	I.		icjoiiii	4b. City.	Town, or	Location of	of Death	0.3	4c. County		
	Examin	er	702 Laurel Av		,,,,,				City				ceste	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I		If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Births	place (State or Foreign ntry)
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	ow ow		10a. State 10b. County		10c. City	r, Town or Lo	cation						1	10d. Inside City Limits
	a-fah	ctor	Maryland Worce	ster	00	cean C	ity							1 ☐ Yes 2 🖾 No
	or 28	Directo	10e. Street and Number				10f. Zip				1	0g. Citizen of V		ntry?
	e 23e		702 Laurel Ave		cedent Ever in U.	S 13 1		1842		nin? (Sne	oify Vae or No-		JSA e - Americ	cen Indian,
036	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or itama 23e or 28e-f ahow marked other than "natural", it is remail to notified at imatic event, the Madical Exerting Instruments	by Funeral	1 Never Married 2 Marr 3 Widowed 4 Divorced	Armed F	orces? 2 \s}No		f Yes, spec		Specify:	Puerto	ecify Yes or No- Rican, etc.)	Blac	white,	etc.
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nor	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (S)		State Roc	ck Crec Ceme	natory or of	ther place	e) A		1.	Washing	,	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury goother treumatic evones.		21. Signature of Funeral Service			22	Name an	d Addres	s of Facilit	v				ЪС
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	Funeral		5. Social Security Number 6. Sec. 231–20–3138	ox 7.Aga ⊐M.2X∑F	e (In yrs. last		If Under Months	1 Year Days	If Under :		8. Date of Bir (Month, Da	rth ay, Year))	9. Birthp	lece (State or Foreign
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	land ow		10a. State 10b. County		10c. City, T	own or Lo	cation							1	0d. Inside City Limits
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Baltimore, Maryland 21215-0036	- E # #	1	21. Signature of Funeral Service License		Tionego	Washington, and					1				ryland
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1944	Physician //Medical Examiner physician up project physician and project physician and project physician and project physician	Examiner	23a. Part1. Entertine disease, or compishock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to anmediate cause. Enter Underlying Cause (Disease or injury that infittated events resulting in death) Last	Due to (or as a	estive consequence al Fib	Hear re of): rilla re of):	rt Fai			Sardiac or	respiratory ar	rest,			Approximate interval Between Onset and Death
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Funeral Director		5. Social Security Num none Usual Residence of De	1.	ex 7. Ag M 2 ☐ F	90 (In yrs. la 43	sst birthday) Yrs.	Months Days					thplace (State or Foreign puntry) atemala
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hyglene. Department of Health and Mentall Hyglene. Department of Health and Mentall Hyglene. Begins of the stranger of the stranger of the stranger of the stranger of the stranger.	d by Funeral	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	Ever in U.S No	5. 13. V	/as Decedent of I Yes, specify Cub Yes 2□ No	Specify:	(Specify Yes or Ni erto Rican, etc.) itemalar		14. Race - Ame Black, Whit Specify: W	
Baltimore, Maryland 21215-0036 sernit. Pages 1 and 2 should be filled within 72 hours att Department of Helbuth and Marial Hygbinsh mportant: If item 27 is marked other then "natural", or inny injury or other traumatic avant, tra Medical Expris- once.	Be Completed	15 (Specify Elementary/Seconda 4	i. Decedent's Ed only highest gra- ary (0-12)	lucation de completed) College (1-4or 5	5+)	(Give I life. D	ent's Usual Occupind of work done O NOT use retire O TIC WO	during most of word)	vorking		Kind of Business	•
ryland lould be file Mental Hy narked othe	To Be C	17. Father's Name (Fin	onio G	uerra				Mari	ame (First, Middle a Ines	Mi	randa	
Mar Tand 2 st Tealth and m 27 te m		19a. Informant's Name Edwin Gu	erra/B		201-01-	151	Main St	treet		er,	New Yo	rk 10509
Itimore it. Pages 1 urment of H urmant: If ite		20a. Method of Dispos 1 ▼Burial 2 □ C 1 □ Donation 5 [21. Signature Funer	remation 3 🗆 🗎 Other (Specify	1		.Quez		que 4/0		Cl Gi	Location - City or niquimu uatemal	la, a
Derm Depart Impo		> Xluly	Otre	Oh		91 92	TLIP D	RINALD umbia B	FUNER	RAL	SERVIC r Sprin	E,P.A g,Md20910
Physician /Medical Examiner		Immediate Cause (Fin disease or condition resulting in death)	al	a. Quelto (or as	sho	+ u	ound		ac or respiratory a	errest,		Approximate Interval Between Onset and Death
sxecuted n and al-transit	Examiner	Sequentially list condit if any, leading to imme cause. Enter Underlyii Cause (Disease or inju- that initiated events resulting in death) Last	-	b. Due to (or as								
68760, tificate be ex gphysician eas the burial				d								_
Division of Vital Records, P.O. Box 68760, or attending Physician: The law requires that the death certificate be explicated or Affector. After this certificate has been signed by the attending physician in by the funeral director, page 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent prointhe past 12 mo 1 Yes 2 No 9 Unknown	nths?	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal o	death 3⊡í	Ectopic pregnancy Other (specify)	у			23d. Date of deli Month	very Day Year
cords, P. wrequires that been signed be should be detailed	by	Part II. Other significat	nt conditions co	entributing to death be	ut not result	ting in the uni	derlying cause giv	ren in Part I.		obacco Yes 2		the cause of death?
al Reco : The law re cate has bee	Completed										prior to c death?	topsy findings available ompletion of cause of
of Vital F Physician: Th rthis certificate ral director, pag	To Be	25. Was case referred examiner? 1 □ Yes 2 □ No	⊢	Hospital: 1 ☐ Inpatie	nt 2 ∑ZE	R/Outpatient	3□ DOA Oth		eath (Check only o		6 ☐Other (Spec	ıfy)
ision o ttanding Ph death. ctor: After th y the funeral		2 Accident	Pending investigation	28a. Date of Injure (Month, Day)	Yyear) 2 OY C	28b. Time of Injury	28c. Injur Wor M 1		28d. Describe			iot
i Diffe	Certification:	4 Homicide	Could not be determined	building, etc	C. (Specify)	bus	3+0F	>	1705	m, Stat	1000	PAP 80-
the Hospital nin 24 hours e the Funeral i	Medical	one) 2	Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examination	ledge, death on and/or inve	stigation, in my o	pinion, death occ	urred at the time,	date an	d place, and due	to the cause(s)
● ***	-	29b. Signature and title	of certifie	coni-	Pol	Och	29c. Licens	e number			ate signed (Month)	
		30 Name and address	A AI	rollica-	Pol	MKI		enn Stre	et, Balt	imor	ce, Mary	land 21201
Sta Registr	1.0	31. Date filed (Month, L		32. Registra	ar's Signatu	5	Sparks					

			1_ State	artment of Health and Mental Hertificate of Death	2001. 10050						
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of	Death 3. Time of Death						
	Physici Medic/		ESTELLE M. MORAN	MARR	CH 28, 2004 8 45 AM						
	Examin	er	4a. Fecility Name (If not institution, give street and number) Manor Care	4b. City, Town, or Location of Death Silver Spring	4c. County of Death Montgomery						
-	Funeral	9	5 Social Security Number 6 Sex 7. Age (In vrs. last birthday	If Under 1 Year If Under 24 Hrs. 8, Date of I							
100	Director		558-18-9200 1 N 2 K 83 Yrs.		11,1920 California						
	yland iow	Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits						
	Ba-f st		Maryland Prince George's College	Park	1 XYes 2 □ No						
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatile and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exemiter must be notified at once.		10e. Street and Number 4904 Blackfoot Road	10f. Zip Code 20740	10g. Citizen of What Country? United States						
			11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.						
36	irs afte	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give \(\hat{\chi}\) 3 ☑ Widowed 4 □ Divorced Year of Dates:	1 ☐ Yes 2 ☐XNo Specify:	Specify: White						
Maryland 21215-0036	72 hou	To Be Completed	15. Decedent's Education 16a. Dece	16b. Kind of Business/Industry							
	within ane. than		Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired) Care Provider	Day care						
	Hygie other		17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd							
	should be ind Mental is marked o		Louis Henry Lacabanne	Ethel Marie	Johnson						
	d 2 shoth and 7 is m			ing Address (Street and Number or Rural Route Num							
	s 1 and f Health Item 27 other tr		20a. Method of Disposition 20b. Place of Disposition	Blackfoot Road College osition (Name of matory or other place) Date	Park Maryland 20740 20c. Location - City or Town, State						
Baltimore,	Pages ment of ant: # It ury or o			Jashington Cem. 4/1/2004	Adelphi, Maryland						
Balt	permit. Pag Department Important: any injury once.		21 Signature of Funeral Service Licensee	2 Name and Address of Facility	ral Home, P.A. Itsville, Maryland 20705						
7	89	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between								
	Physician		Immediate Cause (Final disease or condition resulting in death) a. CEREBROVAS CULAR ACIDENT Due to (or as a consequence of):								
	/Medical Examiner										
	D H		f any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
	xecute and		Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):								
8760,	eath certificate be executed attending physician and for use as the burial-transit	cal E	d								
9	ertifica ling ph	Med	IF FEMALE:								
Вох	that the death cer ed by the attendin detached for use	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year						
P.O.	at the d by the	hysl	9 ☐ Unknown 9 ☐ Unknown								
	se of	Medical Certification; To Be Completed by F	Part II. Other significant conditions contributing to death but not resulting in the u		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Minknown						
Records,	aw requir is been si 2 should		DIABETES MEI	1 7 7 / S 24a. We							
E B				aut per 1 □ Yes	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No						
Vital	Attending Physician: The Ir death. ector: After this certificate ha by the funeral director, page		25. Was case referred to medical examiner?	26. Place of Death (Check only							
ot	g Phys er this eral di		1 ☐ Yes 2 ☐ M6	nt 3 DOA 4 nursing Home 5 Re	sidence 6 Other (Specify) e how injury occurred						
sion	ttending f death. stor: After the funer		2 Accident investigation	M 1 Yes 2 No							
Division	To the Hospital or Attending Phwithin 24 hours attended to the Funeral Director. After the completely filled in by the funeral		3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide	reet, factory, office 28f. Location City or T	actory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
_	To the Hospital or within 24 hours afte To the Funeral Dirt completely filled in I		29a. Certifier (Check only 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
	the Hin 24 the Fu		one) and manner stated. 29b. Signature and title of certifier	29c. License number							
	5 1× 5 8		Signature and time of certains	738571	29d. Date signed (Month, Day, Year)						
	10		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) 10810 C'ENNERTICII	+ Avenue						
			31 Date filed (Month, Day, Year) 32. Registrar's Signature	ISER PERMAN	ENTE KOCKUTHEM						
	Sta Registr	0	DR 02 2004	Soukel							

State of Maryland / Department of Health and Mental Hygiene

					State of	Marylan		rtificate of	nealth and f Death	wentai n	, ,	2004	12200
	•	M	1. Decedent's Nam	ne (First, Middle, L	est)			_		2. Date of D	eath		3. Time of Death
	Physicia	_	Vernon E. Mower							March	31, 2	Year 004	5:00 A.M.
*	/Medic Examin		4a Facility Name (i		ive street and num	ber)			4b. City, Town, or			ounty of Death	
	Examin		Sligo Cr	eek Nurs	ing Home				Takoma P	ark	Мо	ntgome	rv
	Funeral		5. Social Security N			. Age (In yrs. I	ast birthday)	If Under 1 Year	r If Under 24 Hrs	s. 8. Date of B			place (State or Foreign ntry)
	Director		579-24-7731 1MM 2 F 79 Yrs. Months 1 Usual Residence of Decedent					Months Days	s Hours Min	Sept.	16, 19	24 Mar	yland
	show dat	_	10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits 1 ☐ Yes 2X No	
	M e M	Funeral Director	Maryland	Montgor	nery	T	akoma						TEL TES ZAJINO
	it t		10e. Street and Nur	mber				10f. Zip Code			10g. Citizer	of What Cou	ntry?
	238	ē	921 Pros	pect Stree	et Apt. #3	3		20912			Unite	d State	es
	r de	ne l	11. Marital Status		12. Was Deced	es?	5. 13. V	Vas Decedent of Yes, specify Cut	Hispanic Origin? (5 ban, Mexican, Puer	Specify Yes or Noto Rican, etc.)	0- 14.	Race - Ameri Black, White,	
21215-0020	Irs a	اچ	1 ☐ Never Marri 3 🏿 Widowed	ied 2□ Married 4□ Divorced	1 🕅 Yes 2 If Yes, Give Year or Dat	l□No es:WW II		□Yes 2MAN				ecify: Whi	
2-0	"netural",	To Be Completed	(\$800	15. Decedent's E	Education		16a. Deced	ent's Usual Occu	pation	ul-im m	16b. Kind	of Business/In	dustry
21	thin ?	죓	Elementary/Seco	oify only highest g	College (1-4	for 5+)	life. E	OO NOT use retire	e during most of wo ed)	nking			
21	gien gien	5			1		Analy	yst			Feder	cal Gov	ernment
Maryland	s should be filed within and Mentel Hygiane. s marked other then " numatic event, the Men	e l	17. Father's Name	(First, Middle, Les	t)				18. Mother's Na	me (First, Middle	e, <i>Maiden S</i> u	rname)	
<u> </u>	uid b Aente rked tre	0	Jesse Tay	ylor Mow	er				Eleanor	Argent			
ary	bug Em		19a. Informant's Na	ame/Relationship	(Type, Print)		19b. Mailin	g Address (Stree	at and Number or R	u <i>ral Route Numi</i>	ber, City or To	own, State, Zip	Code)
Σ	nd 2 alth e 27 is		Vernon E	. Mower.	Jr./Son				Street Apt				
ē,	S 1 a f Hei frem othe	İ	20a. Method of Disp	position		20b. Pla				April		ion - City or To	
Baltimore,	permit. Peges 1 and 2 Depertment of Health e important: if item 27 is any injury or other tra once.		4 Donation	5 ☐ Other (Spec		ate Mon C1	.ematoi	sition (Name of patory or other pla rium, In	c.	1, 2004	Bethe	sda, M	aryland
Ba	permit Deper impor any in		21. Signature of Fu	neral Service Lice	nsee	M0135	3 Ro	Name and Addr ckville, ckville	ess of Facility RC , Inc. 30 , Marylan	bert A. O West 1 d 20850	Pumph Montgo: -2805	rey Fun mery Av	neral Home/ venue
		7	23a. Part 1. Enter the shock, or hear	he disease, or cor	nolications that cau	sed the death.	1						Approximate Interval Between
	Physician		SHOOK, OF HOU	it idiate. List only	one cause on eac	ar iirie.						1	Onset and Death
<i>y</i> :	/Medical		Immediate Cause (disease or condition	Final	_{a.} Myocar	eddal T	nforet	don					
	Examiner	Ì	resulting in death)	"	a. Hyocai							1	
	ntificate be executed ng physician and est the buriel-transit	ē	Due to (or as a consequence of): Diabetes Mellitus										
			Sequentially list cor	nditions	b. Diabet	Due to (or as a consequence of):							
oʻ	death certificate be executed e ettending physician and id for use es the buriel-transi	Ĭ	if any, leading to im cause. Enter Under	mediate rlying	Conges	Congestive Heart Failure							
68760,	ysicii	20	Cause (Disease of Injury C. — That injuries of the Common										
	g ph es th	8	resulting in death) L	_ast		200 10 (01	u	51,50				-	
Вох	ndin use	2			d								
m	d for		Part II. Othar aignifi	icant conditions	contributing to don't	h hut not rooul	tina in the	dedictes acres with	one in Book I	mt Bid			
P.0	the ache	rnysician/m	rait II. Othar alginii	cant conditiona	contributing to deat	n but not resur	ung in the un-	denying cause gr	ven in Part I.		Henry Dan		the cause of death?
	requires that the death ce een signed by the ettendii hould be detached for use	Dy E								10	Yes 2LAIN	lo 3∐Prot	oably 4 ☐ Unknown
Division of Vital Records,	n sig	2								24a. Was	an autopsy		ere autopsy findings
8	~ O 0	Completed								perfe	ormed?	COI	ailable prior to mpletion of cause
Be	hes b	-									37		death?
क	n: The icate h		111		1					1 🗆	Yes 2⊠N	0 1 []Yes 2□ No
₹	ictar certif recto	ונים	25. Was case referr examiner?		Hospital:			Ott		ath (Check only			
ō	Physician: this certific ral director,	2	1 ☐ Yes 2 ☐ 1 27. Manner of Death		1 □ Inp		R/Outpatient	3LI DOA	4 LEN INUISING F	lome 5 ☐ Resi			/)
Z	tat or Attending P rs efter death. et Director: After t led in by the funera	5 '	1 XNatural	5 Pending	28a. Date of I (Month,	Day Year)	28b. Time of Injury	28c. Injur		28d. Describe how injury occurred			
Sig	Attending or death. ector: After by the fune	ğ	2 ☐ Accident 3 ☐ Suicide	investigation 6 □ Could not be	φ	M 1 Yes 2 No							
⋛	or At effect Direct in by		4 ☐ Homicide	determined	28e. Place of	Injury - At hom etc. <i>(Specify)</i>	ne, f <i>ar</i> m, stre	et, factory, office		28f. Location (City or To	Street and Ni wn, State)	ımber or Rura	l Route Number,
	ital or se life	3											
	To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2	Galcal	29a. Certifier (Check only one) (Check one) (Check only one) (Check only one) (Check only one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Che									ated. the cause(s)	
	Within To th		29b. Signature and t	title of certifier	17.0			29c. Licens	se number		29d. Date sig	gned (Month, L	Day, Year)
			D46998						March 31, 2004				
	10 4		30. Name and addre	ess of person who	completed cause of	of death (Item 5	23a) (Type P						
			Steven Te					•	sville. M	arvland	20782		
	State		31. Date filed (Monti			istrar's Signatu		/			20702		
	Registra			PR 0 2 20	· V	never	19	Spark,	2/				
	3,0,1,0		AI	EK O & C	,UT /T		/	/ /					

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les estada estada estada estada estada estada estada estada estada estada estada estada estada estada estada e	1. Decedent's Name	(First, Middle, La	st)				2. Date of Dea	ath	3. Time of Death	
hysician /Medical	Mary Do	lores Mc(Clellan				April	10 2004	3:58 P M	
xaminer	4a. Facility Name (If	not institution, giv	e street and number)		4b. City, Town, or	Location of Death		4c. County of Dea		
	160 Post Road				Rising			Cecil	Cecil	
neral ector	5. Social Security No. 179-26-58	825	Sex 7. Age	(In yrs. last birthday 69 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da October	9. Bir y, Yeer) 9. Bir 20,1934	thplace (State or Foreign ountry) PA	
	Usual Residence of 10a. State	Decedent 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits	
- io	MD	Cecil		Rising					1 Tes 2 No	
any injury or other traumatic avent, the Medical Examinar must be notified at once. To Be Completed by Funeral Director	10e. Street and Num			Kasang	10f. Zip Code			10g. Citizen of What C		
□	160 Posa				21911			USA	ountry :	
era	11. Marital Status	- 1000a	12. Was Decedent E	ver in U.S. 13.		spanic Origin? (Sp	ecify Yes or No-		encan Indian.	
臣	1 Never Marrie	ed 2X Married	Armed Forces? 1 ☐ Yes 2 XN	0	Was Decedent of Hi If Yes, specify Cuba		Rican, etc.)		te, etc.	
þ	3 ☐ Widowed	4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify: Wh.	ite	
Completed	(Sogoi	15. Decedent's Edity only highest gra	ducation	16a. Dece	edent's Usual Occupa	ation		16b. Kind of Business	/Industry	
old u	Elementary/Secon		College (1-4or 5-	F}	e kind of work done of DO NOT use retired))	ang			
ő	12			Hom	emaker			Own Home		
Be	17. Father's Name ()			18. Mother's Nam	e (First, Middle,	Maiden Sumame)		
To Be	Newton N	1cDowell				Della t	Iershour			
	19a. Informant's Na		• • • • • • • • • • • • • • • • • • • •					r, City or Town, State,	Zip Code)	
			lan/husband		O Post Roc		ig Sun,	MD 21911		
	20a. Method of Disp		Removal from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other place	04-12	Pate 2004	20c. Location - City or	Town, State	
		5 Other (Specify		R.T. Foa	rd Funera	l Home, F	.A.	Rising St	ın, Marylan	
SUC SUC	21. Signature of Pur	h and	See Go	ofie 2	2. Name and Addres	s of Facility R.T Leen Stre	. Foard	Funeral Ho ing Sun, Mi	ome, P.A.	
Examiner Texaminer	Sequentially list con if any, leading to imi- cause. Enter Under	- 1	b. Due to (or as a	consequence of):	1740 . 1.10	7,7,1		, a		
Cal	that initiated events resulting in death) Li	ast	Due to (or as a	consequence or);						
cal	triat initiated events	pregnant nonths?	Due to (or as a d	f pregnancy	□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year	
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tion: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 m 1	pregnant months? No cant conditions conditio	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown ontributing to death but Hospital: 1 Inpatien 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc. ysician: To the best of injer: On the basis of e	f pregnancy Fetel death 3 [me of death 5 [not resulting in the unit of the second s	other (specify) Inderlying cause give Int 3 DOA Othe f 28c. Injury Work' M 1 Y reet, factory, office	26. Place of Death 4 \(\triangle \	24a. Was a autops perform 1 Yes 228d. Describe house 28d. Location (St. City or Town	Month bacco use contribute to es 2 2 No 3 pr no 24b. Were au prior to death? 2 2 No 1 yes e) ence 6 Other (Spec ow injury occurred reet and Number or Ru	the cause of death? the cause of death? bably 4 Unknown topsy findings available completion of cause of 2 No sify)	
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tuneral director, page 2 should be detached for use as the but on: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2	pregnant months? No cant conditions conditio	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown ontributing to death but Hospital: 1 Inpatien 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc. ysician: To the best of injer: On the basis of e	f pregnancy f pregnancy f pregnancy f pregnancy f pregnancy f pregnancy graph t 2	other (specify) Inderlying cause give Int 3 DOA Other f 28c. Injury Work M 1 Y reet, factory, office th occurred at the time vestigation, in my opi 29c. License	26. Place of Death 4 \(\text{Nursing Ho} \) at es 2 \(\text{No} \) a, date and place, anion, death occurrence.	24a. Was a autops perform 1 Yes 28d. Describe how 28d. Location (St. City or Town and due to the caled at the time, di	Month bacco use contribute to es 2 2 No 3 pr no year 2	the cause of death? obably 4 Unknown toppy findings available completion of cause of 2 No sify) ral Route Number, stated. to the cause(s)	
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		For State	State of Marylan	d / Depa	artment o		Mental Hygi	ene	04 1236
		Registrar 1. Decedent's Name (First, Middle, Las	<i>t</i>)		lineate	UI Deali I	2. Date of Death		3. Time of Death
Physic	ian	Mae Catherine	Morgan				April 7	Day Y	8:40 P M
/Med Exami		4a. Facility Name (If not institution, give			4b. City, To	wn, or Location of Deat		4c. County of	
Exami	ner	Genesis Elder Ca			La	Plata		Cr	narles
Funeral		5. Social Security Number 6. So	7. Age (In yrs.	last birthday)	If Under 1				. Birthplace (State or Foreign Country)
Director		217-30-0622	□M 2K1F 89	Yrs.	Wionthis	ays riodis initi	Aug. 20	, 1914 V	irginia
p .		Usual Residence of Decedent 10a. State 10b. County	10c Cit	v. Town or Lo	ocation				10d. Inside City Limits
sho	5			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,041.011				1 ☐ Yes 🎗 🖾 No
the M	ect	Maryland Charles 10e. Street and Number	W	aldorf	10f. Zip Co	de	10	g. Citizen of Wha	at Country?
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28e-f show aumetic event, the Marked Examination or items 23b.	Funeral Directo	8813 Silver Leaf S	:+		2060			USA	at oouthly.
leath ns 23	era	11. Marital Status	12. Was Decedent Ever in U	.S. 13.	-1	of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No-	14. Race -	American Indian,
riter	E	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2/ No	1	If Yes, specify		to Rican, etc.)		White, etc.
urs a	b	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 Yes 2L	No Specify:		Specify:	White
Dermit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumetic event, Ite Moules Examples.	Completed by	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	dent's Usual C	ccupation lone during most of wo etired)	rking	6b. Kind of Busin	ness/Industry
ithin Per	np i	Elementary/Secondary (0-12)	College (1-4or 5+)	1				0 11	
led w lygier her ti	ပိ	12			Homemal		me (First, Middle, M	Own Hom	e
be fi	Be	17. Father's Name (First, Middle, Last) William Andrew Cun	how] and						
should be and Mental s marked o	ို	19a. Informant's Name/Relationship		10h Maili	ng Address /S	treet and Number or Ri	May Blox		ate Zin Code)
d 2 sl th an 7 is r		Betty M. Buchanan	** * *			Drive, Po			116, 2.10 0006)
ges 1 and 2 should to f Health and Mer If item 27 is marks or other traumetic		20a. Method of Disposition	20b, F	Place of Dispo	sition (Name	of		Oc. Location - Cit	ty or Town, State
Pages nent of nnt: If it		1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Hemoval from State		matory`or othe Memoria	al Gdns 4-1	2-04 Wa	ldorf,	MD
permit. Pages Department of Important: If is any injury or once.		21. Signature of Funeral Service Licen					Tip.	craori,	
Depa impo any ir		Dill All Q.	Laun		untt F	uneral Homo ox 156, wa	e ldorf MD	20604	
		23a. Part1. Enter the disease, or com shock, or heart failure. List only							Approximate Interval Between
Physician		Immediate Cause (Final	one cause on each line.	714	C'E	DILLAT	1001		Onset and Death
/Medical		disease or condition resulting in death)	a. Due to (or as a consec	uence of):	1 1 .	SKILLE	001		TRA
Examine		The state of the s	b						
7 -	je l	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	juence of):					
cuter	Examiner	Cause (Disease or injury that initiated events	c						
te be executed ysician and ue burial-transit	EX	resulting in death) Last	Due to (or as a consec	(uence of):					
ate b	dicai		d						
entific ding p	Completed by Physician/Medi	IF FEMALE:	23c. If yes, outcome of pregna	ancu/				201 0-1-	. A. e.
attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	il death 3	∃Ectopic pregi ∃ Other <i>(speci</i>			23d. Date of Month	
the de	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	9 Unknown	ieatii 5	1 Other (speci	y/			
is or Attending Physician: The law requires that the death certifical after death. Director: After this certificate has been signed by the attending ph in by the funeral director: page 2 should be detached for use as the	H.	Part II. Other significant conditions c	ontributing to death but not res	ulting in the u	nderlying caus	e given in Part I.	23e. Did tob	acco use contribu	ite to the cause of death?
uires sign td be	d b	SEVERE O	SHEOARTH	Riti-	5		1 ☐ Ye	s 2□No 3[Probably Unknown
req beer shou	ete						24a. Was an	24b. We	re autopsy findings available
he la e has	E G						autopsy	ed? prio	r to completion of cause of the
ificate	ပိ	25. Was case referred to medical				26. Place of De	1 Yes 2 ath (Check only one	70.	Yes 2□No
s cert	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA	0.1	dome 5 ☐ Resider	-	(Specify)
g Phy er thi		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	-	Injury at Work?	28d. Describe ho		
ath. r: Aft	atio	1 Natural 5 Pending 2 Accident investigation		Injury	М	1 ☐ Yes 2 ☐ No			
Atte	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, sti	reet, factory, o	fice	28f. Location (Str. City or Town,	eet and Number (or Rural Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Certification;		2211311.g; 010. (OPB011				, , , , , , , , , , , , , , , , , , , ,		
hour uner			ysicien: To the best of my knoniner: On the basis of examina						
the H in 24 the Fr	ledical	one)	and manner stated.						
To t To t	Σ	29b. Signature and title of certifier	'X'	21 4	29c. L	cense number	29	d. Date signed (A	Month, Day, Year)
		How	1 MHE	MICH	D	14436	A	Paril 0	8 2004
. 0 -		30. Name and address of person who		-		o 100 Li-1	done MD	20602	,
mp 2		Dr. Ashvin J. Pat	el, 102 Mello	n cour	ı, Suit	e 102, Wal	uorr, MD	<u> </u>	
S Regis	tate	31. Date filed (Month, Ap Read) 9	2004 32. Registrar's Signa	15	GOO!	•			

			1 = For State Registrar		artment of Health and Me rtificate of Death	ental Hygien	2001 1000
	Physici /Medio	cal	Decedent's Name (First, Middle, Last) Helen Evelyn Mile Aa. Facility Name (If not institution, give to the content of the conten	S		march 2	year 3. Time of Death A 1 2004 05:20 M
	Examir	ier	Washington County 5. Social Security Number 6. Sex	Hospital	Hagerstown		Washington
	Funeral Director			M 2⊠F 69 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 04/12/1934	9. Birthplace (State or Foreign Country) WV
	rith the Marylan or 28a-f show se notified at	Director	MD Washingt 10e. Street and Number	on Hagersto	WN 10f. Zip Code	10g. C	10d. Inside City Limits 1 1 Yes 2 □ No Citizen of What Country?
036	72 hours after death with the Maryland natural', or Itama 23a or 28a-1 ehow dical Exaciliser must be notified at	by Funeral	701 Forest Drive 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ☐ Yes 2 🔀 No	21740 Was Decedent of Hispanic Origin? (Specifyes, specify Cuban, Mexican, Puerto R	ify Yes or No- lican, etc.)	A 14. Race - American Indian, Black, White, etc. Specify: Black
121215-0036	I within plene. r than "	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+) (Give life. I	dent's Usual Occupation kind of work done during most of working DO NOT use retired) er Aid	Dis	Kind of Business/Industry Sability Services
Maryland	Mental Mental arked o	To Be	17. Father's Name (First, Middle, Last) Charles H. Brooks		18. Mother's Name Minnie A	. Fisher	,
	1 and 2 sho Health and Iom 27 io m		19a. Informant's Name/Relationship (Type Timothy L. Miles 20a. Method of Disposition	/ Son 954 N	g Address (Street and Number or Rural oland Driver, Hages sition (Name of	rstown, M	21740
Baltimore,	permit. Pages Department of I Important: If ite eny injury or of		1 XBurial 2 Cremation 3 R '4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	Rose Hill	natory or other place)	/2004 Ha	
	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do not entre cause on each line. a. ue to (or as a consequence of): Due to (or as a consequence of):	er the mode of dying, such as cardiac or	respiratory rrest,	Approximate Interval Between Onset and Death
Box 68760,	death certificate be executed e attending physician and nd for use as the buriat-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past J2 months?	Due to (or as a consequence of): 3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)	12:00:2	23d. Date of delivery Month Day Year
rds, P.O.	ss that the d gned by the se detached	ρ	1 ☐ Yes → No 9 ☐ Uhknown Part II. Other significant conditions con	9 Unknown		. /	use contribute to the cause of death?
Vital Records,	The ate h page	e Completed	25. Was case referred to medical			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
of	ding Phys	Certification: To B	examiner?	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28b. Place of Injury - At home, farm, stre building, etc. (Specify)	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	a 5 ☐ Residence d. Describe how inju	nd Number or Rural Route Number,
۵	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical Cert	29a. Certifier To Certifying Phys	sician: To the best of my knowledge, death her: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place, and estigation, in my opinion, death occurred	d due to the cause(s at the time, date an	and manner as stated
•	To the within 2 To the complete	Me	29b. Signature and fittle of certifier 30. Name by address of person who could	mpleted cause of death (Item 23a) (Type, F	29c. License number	29d. Da	ite signed (Month, Day, Year)
9	Sta	te	31. Date filed (Month Day ry ear)	32. R. strar's Signature	CT. Hage	ndown	, MD 21740 -

			For State	State of Marylan					0001	10061
			Registrar 1. Decedent's Name (First, Mipole, La:	st)	Cei	rtificate of	Death	2. Date of Deat	eg. No. 2004	3. Time of Death
	Physici		Charles Kus	sell Murr	44			Month	Day S. 2004	3:58 PM
	/Medio Examin		4e. Fecility Name (If not institution, give		~	4b. City, Town, o	r Location of Death	Trial Cr	4c. County of Death	90
			Washington Count			Hagersto			Washingto	
	Funeral		5. Social Security Number 6. S 214-09-1609	OM 2DE	last birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		place (Stete or Foreign ntry)
	Director	}	Usual Residence of Decedent	X 86				Dec. 7,	1917 Mary	land
	nylanc how		10a. State 10b. County	10c. City	y, Town or Lo	cation			1	0d. Inside City Limits
	8a-f	cto	MD Washingt	on Hag	erstow					1 ☐ Yes 2 X No
	with the or 2	Dire	10e. Street and Number 18031 Putter Dri	We.		10f. Zip Code 21740		11	0g. Citizen of What Cour	ntry?
	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f show he Madical Exercities fraud the motified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.		Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	U.S.A.	can Indian,
9	after or Iter	Fun	1 Never Married 2 Marned	Armed Forces? 1 TYPes 2 No 194 If Yes, Give	16	t Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)	Black, White,	
003	ural',	d by	3 Widowed 4 Divorced	Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify: Whi	te
15	n 72 h	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	ing	16b. Kind of Business/In	dustry
212	withi	omp	Elementary/Secondary (0-12)	College (1-4or 5+) 2	_	ector	•/	τ	J.S. Postal	Service
פ	e filed at Hygi other vent, I	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name			302.1200
ylaı	should be and Mentail marked o	ToE	Charles Russell N	furray, Sr.			Beulah V	irginia	Snyder	
Maryland 21215-0036	O1 (0 m M		19a. Informant's Name/Relationship	**					City or Town, State, Zip	Code)
	1 and 2 Health Ism 27		Mildred E. Murray 20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of	Drive Hag		MD 21740 20c. Location - City or To	own State
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specifi	Removal from State	emetery, cren	natory or other plac	1			
alti	permit. F Departme Importan any injur	1	21. Signature of Funeral Service Licen	, 1100	22	en Cemete	ry 3/22/	ZUU4 E t Haven	Hagerstown, Funeral Cha	MD nel
ä	Depar Impor	V I	5 Elphon Rs. S	Suman	16	01 Penns	ylvania A	ve. Hage	erstown, MD	21742
	Physician /Medical Examiner		23a. Part1. Enfer the disease, or com, shock, or heart tailure. List only Immediate Cause (final disease or condition resulting in death)	plication that caused the death one cause on each line. a	13il at	0	g, such as cardiac o		ieptic Shock	Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertyling Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence) d.						
P.O. Box 68	The law requires that the death certific 11e has been signed by the attending pl 2ge 2 should be detached for use as	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
<u>م</u>	s that	y Pt	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to th	e cause of death?
Vital Records,	w require been sig should b	edb	parki	ison's disease	•			1 ☐ Ye	s 2⊡No 3□Prob	ably 4 Unknown
ecc	law re as be 2 sho	plet	The state of the s					24a. Was an		osy findings available inpletion of cause of
<u> </u>	: The law cate has page 2:	Con						perform		
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death			
ō	Physician: r this certifica rral director, p	. To	1 Yes 2 No	1 L⊈Inpatient 2 ⊔ I	ER/Outpatien 28b. Time of	1 3 DOA	4 Nursing no	me 5 Resider 28d. Describe ho	nce 6 Other (Specify winjury occurred	")
ion	nding th. r: Afte e fune	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		<br Yes 2 □No		,,	
Division of	al or Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Str. City or Town,	reet and Number or Rura , State)	l Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certifica completely filled in by the funeral director.	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowniner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the time restigation, in my of	ne, date and place, pinion, death occurr	and due to the ca ed at the time, da	use(s) and manner as st ite and place, and due to	ated. the cause(s)
ŀ		Σ	29b. Signature and title of certifies	ly mo		29c. License	1070579		od. Date signed (Month, 18	Dey, Year)
-	2410x1		30. Name and address of person who is the first of the state of the st	completed cause of death (Item	23a) (Type,	Print) N AVE	MAGELOT	TOWN M	0 21740	
4	Sta	te	31. Date tiled (Month, Pay, Year)	32. Begistrar's Signat				· · · · · · · · · · · · · · · · · · ·		

Maryland Washington Hagerstown 10f. Zip Code 10g. Chizan of What Country? 17		_ 1	For State Registrar	State of Maryland	/ Depart		lealth and I	Mental Hy	_	104 1236
Second Second Parkinson Parkinson S. Sum Second Second Parkinson Parkinson S. Sum Second Second Parkinson S. Sum Second Second Parkinson S. Sum Second Second Parkinson S. Sum Second Second Parkinson S. Sum Second Second Parkinson S. Sum Second Second Parkinson S. Sum Second Second Parkinson S. Sum Second Second Parkinson S. Sum Second Second Parkinson S. Sum Second Second Parkinson S. Sum Second Second Parkinson S. Sum Second Second Parkinson Second Second Parkinson Second Second Parkinson Second Pa			Peggy Louise MARL	IN				Month	Day	2004 7:37 P
220—58—4373 105 County 105 Cept, Term of Location 105 Cept, Term of		er	Washington County	Hospital		Hage	erstown		Wash	hington
17. Father's Name (First, Middle, Malson Sumanna) 18. Mother's Name (First, Middle, Malson Sumanna) 19. Malmond Ray Moats 19. Edith Louise Shaff Four Number of Paral Flouris Number of Paral	Director		220-58-4373 Usuel Residence of Decedent	□M 2X7F 51	Yrs. M		Hours Min.	Sept.	y, Year) 17 1952	Maryland
17 Father's Name (First, Middle, Makes Dumanna) 18 Mother's Name (First, Middle, Makes Dumanna) 19	he Marylan Sa-f show	ector	Maryland Washing		agersto	wn			10g Citizen of	1 X Yes 2 □ I
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Thysician interesting to design the design of the design o	artment of ortent: If It injury or o		* 4 ☐ Donation 5 ☐ Other (Specify,	Rose	e H il l	Cemete	ry 3/22			
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9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death part II allow an autopsy prior to completion of cau death page of the state of t	certifica nding ph use as th	cal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	y eath 3⊟Eo		у			
24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Wanner of Death 1	that the c ed by the detached	Physi	9 🗆 Unknown		ng in the unde	orlying cause gr	ven in Part I.	23e. Did t	obacco use con	ntribute to the cause of death?
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1 Natural 2 Accident 3 Suicide 4 Homicide 4 Ho	sicien certifi irector	8	examiner?	Hospital: 1 Dippatient 2 TER	3/Outnationt	3[7] DOA 0th	205			har (Snacifu)
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Jing After fune	ication: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Inju Wo M 1	ry at rk?	28d. Describe	how injury occur	rred
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUCK WER UD - 12521 - OFF HILL NE. HAGERSCON MD 2104	within 24 f To the Fu completely	Medic	one)		n and/or inves	29c. Licen	se number	irred at the time,	29d. Date signe	ed (Month, Day, Year)
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			1 - For State Registrar	State of Maryland	d / Depa		lealth and	Mental Hyg	iene 19. No.2004	12366
,	Physici /Medio Examin	al	Decedent's Name (First, Middle, La Bernard Eugene I 4a. Fecility Name (If not institution, give	Myers		4b. City, Town, o	r Location of Dea	2. Date of Deat Month	Day Year 3 200 4	
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	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 show ha Madical Exprinted must be incifficial at	rector	Usual Residence of Decedent 10a. State 10b. County Md. Frec 10e. Street and Number	derick 10c. City,	, Town or Lo Myer	cation SVI11e		11	0g. Citizen of Whet Co	10d. Inside City Limits 1 Tyes 2 No
	er death with Items 23s or rec must be	Funeral Director	12125 Loy Wolfe I	12. Was Decedent Ever in U.S Armed Forces?	S. 13. \	2	1773 ispanic Origin? (in, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	U . S . 14. Race - Ame Black, White	nican Indian,
15-0036	72 hours aft "natural", or edical Exam	by	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gr.	1 Yes 2 X No If Yes, Give Year or Dates: ducation ade completed)	16a Decec	1 ☐ Yes 2 ☒ No dent's Usual Occup kind of work done DO NOT use retired	ation	orking	Specify: 1/2 16b. Kind of Business/	Thite Tindustry
Maryland 21215-0036	Hygi Hygi other	Be Completed	Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Last LeRoy Myers	College (1-4or 5+)	1116. 1	Mainten	ance 18. Mother's Na	ame (First, Middle, M		ot.
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Baltimore,	t. Page rtment o rtant: If njury or		20a. Method of Disposition 1 X Burial 2 Cremation 3 C 4 Donation 5 Other (Special Service Liperature of Funeral Service Liperature of Service Liperature Original Conference Liperature of Service Liperature of Service L	Ple.	asant	sition (Name of natory or other place Valley C Name and Addre	em. Apr.	3,2004 S	eadbury Ave	Md.
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	. Do not ent			Smithsbu	rg,Md. 217	
760,	Physician /Medical Examiner physician and physician and physician and the priral-transit	dical Examiner	disease or condition resulting in death) Sequentially list conditions. If any least of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	ence of):	et in	neti			(04)
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ecords, P	w requires that been signed b should be deta	by	Part II. Other significent conditions tent Rema						acco use contribute lo	the cause of death? obably 4 Onknown
Vital Reco		e Completed						24e. Was ar autops perform 1 Yes 2	prior to death? No 1 □ Yes	atopsy findings available completion of cause of
of	ig Phys ter this neral dir	To B	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4 🗍 Nursing	eath (Check only one Home 5 Reside 28d. Describe ho	nce 6 Other (Spec	cify)
Division	ital or Attending irs after death. raf Director: Alter led in by the fune	Certification:	3 Suicide 6 Could not be determined		me, farm, str	eet, factory, office		28f. Location (Sti City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospital or Atterviewithin 24 hours after de To the Funeral Directo completely filled in by the	Medical		hysician: To the best of my know miner: On the basis of examinati and manner stated.			pinion, death occ	curred at the time, da		to the cause(s)
1,	3		30. Name and address of person who	completed cause of death (Item	23a) (Tvps.	D (8	જિલ્લુ		MARCH 31,	2004
5	Sta	ite_	VA S A ~ T DA 31 Date filed (Month, Day Year) 1	774 400 33	- ~	11115-	MAC	ERSTON	N MO	21740
Ī	Regist	rar	APRUI	2004 Jacon	10. 19					

			1- State Registrar	State of Marylan	nd / Depa		lealth and	Mental Hyg	_	
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>	Examir		4a. Fecility Name (If not institution, give			4b. City, Town, o	or Location of Dea	th	4c. County o	
	<u>,</u>		Clearview Nursi				agerstow			shington
ł	Funeral Director		5. Social Security Number 6. Sec. 217-10-0123		last birthday) B6 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		2,1917	9. Birthplace (State or Foreign Country) Maryland
	land ow		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	Mary a-f sh	tor	Maryland Washi	naton	h	/illiamsp	ort			1 ☐ Yes 2 🕱 No
	or 28,	lrec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of WI	nat Country?
	23a c	Funeral Director	14742 Falling Wa	ters Road			21795			USA
	er deg	une	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	l.S. 13.	Was Decedent of H	lispanic Origin? (an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		- American Indian, White, etc.
Maryland 21215-0036	d within 72 hours after death with the Maryland jaies. Than "natural", or Itema 23a or 28a-f show I'ra Medical Examinar must be notified at	b	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 X No If Yes, Give Year or Dates:		1□Yes 2风No	Specify:		Specify:	White
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2	within lene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	//fe. /	DO NOT use retire			0 11 1	
N	be filed withir ital Hygiene. id other than event, Ite M		6 17. Father's Name (First, Middle, Last)			Layout		me (First, Middle, A		ing Equip. Manu.
a	9 d a 9	Be C	Lincoln Robert	Myers			Ida	Mae Dav		
<u></u>	d 2 should be th and Mental 7 Is marked of traumatic ev	2	19a. Informant's Name/Relationship (T		19b. Mailir	ng Address (Street		Tural Route Number		tate, Zip Code)
S	od 2 :		James R. Myers	- Son	296	Woodstoc	k Rd. Fa	yettevill	e-PA 1	7222
ā,	of Health of Health item 27 I		20a. Method of Disposition	20b. P	Place of Dispo	sition (Name of natory or other place				ity or Town, State
Baltimore,	permit. Pages I Department of H Important: If ite any injury or ot once.		YXBurial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	-	Mem. Pa	· I	3,2004 W	illiamsı	ort,Maryland
=	mit.		21 Signature of Funeral Service Licens			Horne fu			11114	or randi grand
ñ	Depa Impo any ir		1 Mitte					ue St. Wi	Hiamso	ort.MD 21795
	Medical Examiner	ılner	23a. Part. Enter the disease, or comp shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury)	a	juence of):	mile	udans		Ε	Interval Between Onset and Death
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.	2 P 8	by Pt	Part II. Other significant conditions co	ntributing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did tob	acco use contrib	ute to the cause of death?
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ပ္သ	as been sign 2 should be	Completed	Dichty Me					24a. Was ar	1 24b. We	re autopsy findings available
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<u> </u>	certificate ector, pag	0	25. Was case referred to medical				26. Place of De	ath (Check only one		
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0	iding Pnysician: th, : Atter this certifica funeral director, p		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injur Wor	y at	28d. Describe ho		
<u>0</u>	Attending r death. ector: After by the fune	atle	2 Accident investigation			M 1	Yes 2 □ No		V	
_	0 = =	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre y)	eet, factory, office		28f. Location (Str City or Town,	eet and Number , State)	or Rural Route Number,
:	within 24 hours after death	Medical (sician: To the best of my kno iner: On the basis of examina and manner stated.						
1	Myithir To th	Me	29b. Signature and title of certifier			29c. Licens				Month, Day, Year)
)	73		- CZNCC	mo		DO	9019		MARCI	31, 2004
	4		30. Name and address of person who c				THA	SERSTO	wa m	021740
i	Sta Regist	_	31. Date filed (Month, Day, Year) APR 0 1 20	32. Registrar's Signa	iture	and s				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 12368 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 22:15P ^M Phillip Phillip 30 2004 Newman March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's 3120 Brightseat Road Lanham 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, 1 Birthplace (Stete or Foreign
Country) **Funeral** Days Hours Min 1 M 2 □ F Washington, DC 217-42-2023 Director 57 1946 Usual Residence of Decedent the Maryland 10a, State) and a successive that the successive successive successive that the successive success 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√ Yes 2 No Director Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 3120 Brightseat Road 20706 U.S.A. Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 132 Yes 2 □ No An If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Army 1 ☐ Yes 2 ☑ No Black Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Printer Government 12th item 27 is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Estella T. Brooks Newman William ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3120 Brightseat Road Lanham, Maryland 20706 Phylette Newman /Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State - to 1 ⊠Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or * 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran's 4/7/2004 Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 arsha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HYPERTENSIVE CARDIONSCULDE /Medical Due to (or as a consequence of): **Examiner** typercipidemin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed ABUSE AND DEPENDENCE Acolloc burial-trans Due to (or as a consequence of): attending physician for use as the buria Myoempial INFAREROND IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) ed by the a been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☑ No 24a. Was an page 2 certificate has autopsy performed? 1 Yes 2**∑** No the Hospitel or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) 10 1 ☐ Yes 2 ☐ No this 28a. Date of Injury (Month, Day Yeer) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

10

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

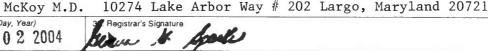
State Registrar

31. Date filed (Month, Day, Year) APR 0 2 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Norman



29c. License number

29d. Date signed (Month, Day, Year)

			State of Marylar	nd / Depa	artment of H	lealth and M	ental Hyg	giene		10000
			Registrar 1. Decedent's Name (First, Middle, Last)	Cei	rtificate of l	Dealii	2. Date of Dea	teg. No. 20	-	3. Time of Death
	Physici	an					Month	Day	Year	
	/Medic	al	Harry Fredrick Nixon, Sr. 4a. Facility Name (If not institution, give street and number)		4b City Town or	r Location of Death	March	28, 2 4c. County of		11:35 A.M.
	Examin	ier	Southern Maryland Hospital		Clinto				e Geor	rae's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day			e (State or Foreign
	Funeral Director		579–30–5795 1\(\overline{\text{Q}}\) M 2□F 76	Yrs.	Months Days	Hours Min.	2/6/28		(Country nter	
	g .		Usual Residence of Decedent				2/0/20			
	death with the Maryland ms 23a or 28e-f show Linual be molified at	ctor	10a. State 10b. County 10c. County P.G.	ity, Town or Lo		Pleasant			10d.	Inside City Limits 1 No 2 No
3	th with the 23a or 28	ai Dire	10e. Street and Number 6706 Blacklog Street		10f. Zip Code	20743		10g. Citizen of W U.S	-	?
35.4	ē # #	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in L Armed Forces? 1 Syes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Spe un, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	Specify:	- American , White, etc. Africa Americ	an–
//215-00	in 72 hou n "natura Nedical I	pieted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of working	ng	16b. Kind of Bus	iness/Indus	try
212	d with	E	11th	7\VT	VCR Techni	ician	I	Private	Indust	cry
$\mathcal{O}_{\mathcal{C}}$ // $\mathcal{S}_{\mathcal{C}}$ Maryland 21215-0036	ild be filed tental Hyg rked othe ilc event,	To Be C	17. Father's Name (First, Middle, Last) Harold Nixon			18. Mother's Name Florer	(First, Middle, I)	
04 Mary	nd 2 shoulth and No. 27 is main		19a. Informant's Name/Relationship (Type, Print) Kevin A. Nixon/Son	1-		and Number or Rural St.,Seat I			itate, <i>Zip C</i> o 0743	de)
S 228. Baltimore,	ages 1 ar ant of Hea it: If Item y or othe		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 1 ★ □ Donation 5 □ Other (Specify)	Place of Dispo cemetery, crer armony	osition (Name of matory or other plac Mem. Parl	k 4/3/0		20c. Location - C Landov		
Baltir ✓	permit. P Departme Importen any injur		21. Signature of Funeral Service Licensee Reny W.	22	Name and Address H.S.Wash:	ss of Facility ington & S	Sons Co.	,Inc.	2004	10
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O. Box 68	To the Hospitel or Attending Physicien: The law requires that the death certificat within 24 hours after death. To the Funerel Diractor: After this certificate has been signed by the attanding phy completely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fett 4 ☐ Pregnant at time of of the pregnant at time of the	aldeath 3□	Ectopic pregnancy Other (specify)			23d. Date Mont	ot delivery h Day	y Year
s, P.	res that t signed by I be detac		Part II. Other significant conditions contributing to death but not re-	sulting in the u	nderlying cause give	en in Part I.		pacco use contrib	oute to the ca	
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	vith To 1	2	29b. Signature and title of certifier		29c. License	number	2	9d. Date signed		
	<i>(</i>		00		104	6418		3-30	1.09	
CRC	5) 1k		30. Name and address of person who completed cause of death (Itel	7501	Print) SUN	atts Rd.	Cliv	nton. n	MD a	10735
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 1 2004	ALUTO SOLE	le					

State of Maryland / Department of Health and Mental Hygiene 2001 12370 State
Ragistra AMEND#10 eperFH3/30/04, BMW, McCo Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 1225 PM Anthony M. Natelli 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
July 13, 1936 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral №** M 2□ F 67 New Jersey 158-26-7262 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itame 23a or 28a-f ahow the Medical Examinar must be notified at 1 ☐ Yes 2√2 No Directo Maryland Montgomery Potomac 10f. Zip Code 10g. Citizen of What Country? 10g Street and Number 20854 9629 Beman Woods Way U.S.A. Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White, etc. 1 Never Married 2 Married ☐Yes 2XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White ò 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired Chairman Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tant: If item 27 is marked other th ijury or other traumatic avent, the Land Development Natelli Communities 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nicholas Natelli Maria Parrillo ೭ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertrude Natelli / Wife 9626 Beman Woods Way, Potomac, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Himportant: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Gabriel's Cem. 3/27/2004 4 ☐ Donation 5 ☐ Other (Specify) Potomac, Maryland ^{22. Name and Address of Facility} Joseph Gawler's Sons, Inc.
5130 Wisconsin Ave., NW, Washington, DC 20016 21. Signature of Funeral Service Licensee MO1296 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Immediate Cause (Final disease or condition resulting in death) Hemerchage Physician Intracerebral /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician at s the burial-t Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Jone 1 ☐ Yes 2 🔼 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Division of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Atter t 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 😿 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 59303 30 MO ited cause of death (Item 23a) (Type, Print) Susurben Hospital Bothesta Maryland 1844 HDUNN, TI. MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Server Lath

29 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death MARCH **Physician** KUTH M. NAUMOWICZ 2004 /Medical 4a. Fecifity Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Columbia Howard Howard County General Hospital If Under 1 Year | If Under 24 Hrs. Vonths Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthpface (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F Yrs. Director 363-26-7664 Apr. 21, 1926 Canada Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Itama 23a or 28a-f show the Modical Examiner want be notified at 1 Yes 2™No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10105 Carillon Drive 21042 USA Funerai death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or Itar any injury or other traumetic event, the Modical Examina 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Yes, Give 'ear or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ⅓Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Colfege (1-4or 5+) 12 Communications Liaison General Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lillian Stainsby John Francis Rivers 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy R. Sherwood/ Daughter 1592 Stowe Road, Reston, VA 20194 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State March 31, Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 2004 Silver Spr. 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. Silver Spring, MD ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 1cure 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 3 WEEKS NEUHONIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner OBSTRUCTIVE PULMOWARY DISEASE CHRONIC YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) burial P.O. Box 68760 Physician/Medical as the the attending phed for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 XNo 3 Ectopic pregnancy Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ MONOCLONAL GAMMONATHY OF CHRONIC DISEASE 1 XYes 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an COROHARY ARTERY DISENSE, HYPERTENSION autopsy performed certificate 2 **X**No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 - Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 138296 20 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 9501 OLD ANNAPOUS RD, SUITE 202, FLLICOTT GTX MB 21042 F. GIBBONS MD 31. Date fifed (Month, Day, Year) 32. Registrar's Signature MAR 30 Registrar

				State	of Maryla	-	artment <i>rtificate</i>			d Mental	Hygie Reg.	00	UL	12372
	Physiciar	1	1. Decedent's Name (First, Midd		P 784.0				-	2. Date of Month	of Death	Day	Year	3. Time of Death
	/Medica		ANN LITTLE: 4a Facility Name (If not institution					4	b. City. Town.	or Location of		29 4c. Count	2004	2400
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	and **	-	Usual Residence of Decedent 10a. State 10b. County	y	10c. (City, Town or Lo	ocation						100	d. Inside City Limits
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lan lan	should be filed and Mental Hygin marked other imatic event,		WILLIAM CLARK	LITTLET	ON				EDNA	MAE CI	ARKE			
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	and lealth m 27	-	CAROLE P. YOU	NG/DAUGH					B, DUN	MORE, W				
Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 ☐ Cremation		m State	Place of Dispo cemetery, crer	netory or oth	er place		Date			City or Towr	n, State
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	State		WILLIAM H. W 31. Date filed (Month, Dey, Year)		M.D. 50 Registrar's Sign		IMANS	LANI	KASTO	N, MD 2	1601			· · · · · · · · · · · · · · · · · · ·
	Registrar		MAR 31	- 40	1 4	1	all in							

ORIGINAL

DHMH 16 Rev 6/95

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Importa eny inj pnce.		21. Signature of Funeral Service Licen	see 10		22. Name and Addre					
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State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Christobal Ochoa 31,2004 /Medical March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 7 / 24 / 1944 Birthplace (State or Foreign Country) **Funeral** 1[XM 2□ F 215-39-4877 59 Director Honduras Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itams 23s or 28s-f show other traumatic event, the Mcdical Experiment, was be notified at Prince George's MD Hyattsville Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20783 7300 Riggs Road #102 Honduras death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Informant: If item 27 is marked other than "natural", or Ital Important: If item 27 is marked other than "natural", or Ital any injury or other traumatic event, the Modical Expunition once. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2 No Yes Give Specify: Honduras à Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodian Nursing Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cecilio Ochoa Rosalia Castro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daisey Ochoa/Wife 7300 Riggs Road #102 Hyattsville, Md20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Tegucigalpa, Honduras 1 ☑ Burial 2 ☐ Cremation 4/09/04 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Cem.Jacaléapa 21. Signatu A of Funeral Ser PHILIP DE RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiagor respiratory arrest, shock, or flear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner. PNU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy õ in the past 12 months? Month Day Year 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by as been si 1 Yes 2 No 3 Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No page certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation М 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check or 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (ten 23a) (Type, Print) 30. Name and address of person who de. SSE 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

Separ

APR 02

		1	For State	State of Mary	land / Depa <i>Cei</i>	artment of F rtificate of	Health and M <i>Death</i>	fental Hyg R	giene 20 (14 12375
	s 5 m	Carl I	Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Dear	th	3. Time of Death
	Physicia		John H. O'Leary					March 2	29 , 2004	12:04A M
5	/Medic	4 (6)	4a. Facility Name (If not institution, give si	treet and number)		4b. City, Town, o	or Location of Death		4c. County of D	
	Examin	ei	Suburban Hospital			Bethes	da		Montgom	ery
	Funeral		5. Social Security Number 6. Sex	7. Age (in	yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day) Jan. 3,		Birthplace (State or Foreign Country) New York
45.7	Director		099-22-4665	M 2 F	73 Yrs.	Wichins	Tiodis items.	Jan. 3,	1931	New York
	p _	H	Usual Residence of Decedent	10	c. City, Town or Lo	eation		<u> </u>		10d. Inside City Limits
	arylar show	_	10a. State 10b. County		•					1 ☐ Yes 2 📉 No
	Ba-f	9 F	Maryland Montgome	ry	Chevy Ch	10f. Zip Code			10g. Citizen of Wha	t Country?
	with th		10e. Street and Number			20815			United S	
	s 23	era	8700 Jones Mill R	Oad 2. Was Decedent Ever	in U.S. 13.		Hispanic Origin? (Sp	ecify Yes or No-		American Indian,
	ter de Itam	Funeral	11. Marital Status 1 Never Married 2 Married	Armed Forces?		If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Black, V	Vhite, etc.
99	urs at	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🂢 No	Specify:		Specify:	White
ĕ	2 hou	ted	15. Decedent's Educ	cation	16a. Dece	dent's Usual Dccup	pation during most of work	rina	16b. Kind of Busine	ess/Industry
2	hin 7	Completed	(Specify only highest grade	College (1-4or 5+)	life.	DO NOT use retire	nd)			
7	giene giene er th	Con		4	Adve	ctising E	xecutive		Publishi	ng
p	d oth	Be	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
<u>X</u>	Ment Ment arka	၉	John A. O'Leary				Marian I		- City - Town Sta	to Zio Codo)
Jar	2 sh and Is m		19a. Informant's Name/Relationship (Type				and Number or Rur			
<u>~</u>	and lealth m 27 her ti		Carole A. O'Leary 20a. Method of Disposition		46U5 20b. Place of Dispo	- Contract - Contract	enue, Bet		Mary Land 20c. Location - City	20814 or Town, State
Baltimore, Maryland 21215-0036	if of H		1 X Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, cre	matory or other pla	1 1			
ij	rtant njury		*4 □ Donation 5 □ Other (Specify) 21. Signature ■ Fine M Service Licens		St. John	2 Name and Addr	ery 2004	ert A. T	Middle vi Pumphrey	llage, NY Funeral Nome/
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, Ite Medical Exercities must be notified at once.		1 Sind	eru, MO	00803 Be	ethesda-C ethesda,	hevy Chas Maryland	e. Inc. 20814-1	7557 Wis 3501	Funeral Home/ consin Avenue
- E	-53-1		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the	death. Do not en	ter the mode of dy	ing, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician	1	Immediate Cause (Final disease or condition	St	ASIS Sy	MORON	1E			Oliset and Death
	/Medical		resulting in death)	Due to (or as a co	onsequence of):	0 0~10				
	Examiner	L	Sequentially list conditions, if any, leading to immediate	Due to (or as a co		JIN IM				
	ed sit	Examlner	cause. Enter Underlying Cause (Disease or injury	D09 10 (0) 43 4 CC	31.36 qualito 01).					
	cate be executed physician and the burial-transit	xan	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):					
8760,	sician buria	dical E		4						
687	ficate g phy: s the	edic							1:	
Box	leath certific attending p	Z/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of p		□Ectopic prøgnand	a.v		23d. Date of	
	death certific e attending p od for use as	Physician/Me	in the past 12 months?	4 Pregnant at time		Other (specify)	-9		Month	Day Year
P.O.	that the de ed by the detached	hys	9 Unknown	9L] Unknown						
S, F	requires that the een signed by th hould be detache	by F	Part II. Other significent conditions cor	ntributing to death but no	ot resulting in the u	underlying cause g	iven in Part I.		_/	te to the cause of death?
ğ	w require been si should I	ted					4-70.74	1 🗆 Y	/es 2,⊠No 3[
ecc	S S S	Completed		ENSIUN,	STATUS	105) (614	tbilo	24a. Was autop	sy prio	e autopsy findings available r to completion of cause of
<u> </u>		Son	VASULAR ACCIDE	NI, MALI	VUTTATION	N.				Yes 2□ No
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		0:	26. Place of Dea			
of Vital Record	hys his	မ	Yes 2 No 27. Manner of Death	1 Inpatient 28a. Date of Injury	28b. Time of	HIL 3LI DOA	4 Nursing 11		dence 6 Other (now injury occurred	Specify)
n	After funer	lo U	U⊠Natural 5 ☐ Pending	(Month, Day Ye	ear) Injury	Wo	ork? ∐Yes 2 □No		, ,	
Division	deatl deatl ctor: y the	fical	3 Suicide 6 Could not be	28e. Place of Injury	- At home, farm, si	treet, factory, office	,			or Rural Route Number,
Div	al or Attending P s after death. al Director: After ted in by the funera	Certification	4 Homicide	building, etc. (S	Specify)			City or Tow	wii, State)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical	29a. Certifier Certifying Phy (Check only 2 Medicel Exami	sician: To the best of m ner: On the basis of ex and manner stated	amination and/or in	th occurred at the nvestigation, in my	time, date and place opinion, death occu	, and due to the or rred at the time, o	cause(s) and manne date and place, and	er as stated. I due to the cause(s)
	within 2 To the complet	Me	29b. Signature and fille of certifier	Gundan		29c. Licer	nse number		29d. Date signed (A	Month, Day, Year)
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	17		1031 7717-110	IWN ROAD	JVINE	202, G.	ATHENSB	Ma, M.	D: 20078	
5.0	St Regist	ate trar	31. Date filed (Month, Day, Year) APR 0 2 20	32. Registrar's		Sport	h			

DHMH 17 Rev 1/2001

John, O'Leary

			1 - For State Registrar	State of Maryland	-	artment of rtificate of		nd Mental H	ygiene	004 12376
	Physici		1. Decedent's Name (First, Middle, Last) Irene Leah 0'	B ri en	300			2. Date of D Month March	Day	2004 3:10 A M
7	/Medic Examin		4a. Fecility Name (If not institution, give :			4b. City, Town,	or Location of			2004 3:10 AM
	LXUIIII		Washington Count	y Hospital		Нас	gerstow	n		Washington
	Funeral Director		5. Social Security Number 6. Sex		ast birthday) Yrs.	If Under 1 Yea Months Days		Min. 8. Date of B	irth 7, 1919	Birthplace (State or Foreign Country) Mary Land
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other treumstic event, the Medical Exeminer must be notified at once.	Funeral Director	10a. State 10b. County Maryland Washin		, Town or Lo	Hager	stown			10d. Inside City Limits XXYes 2 □ No
	a or 2		10e. Street and Number 432 Virginia Ave			10f. Zip Code	21740		10g. Citizen o	f What Country?
	death	eral		12 Was Decedent Ever in U.S	S. 13. V	1		in? (Specify Yes or N Puerto Rican, etc.)	o- 14. Ra	USA ace - American Indian,
21215-0036	ours after or Itel	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	Į.	f Yes, sp <i>eci</i> fy Cui 1 □ Yes 2 No		Puerto Rican, etc.)	Spec	lack, White, etc. White
5	natu Ocal	etec	15. Decedent's Edu (Specify only highest grade	cation e c <i>ompleted)</i>	(Give	ient's Usual Occu	during most	of working	16b. Kind of	Business/Industry
7	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	not use retir Homema				Home
	Hygin Hygin other	Be Co	17. Father's Name (First, Middle, Last)			Homeine		's Name (First, Middle	e, Maiden Suma	
lan	Aental Aental rked c	To B	John Donald Murray	,			La	ura Irene	e Nave	
Maryland	2 should and Men Is marke eumatic		19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailin	g Address (Stree	t and Number	or Rural Route Num	ber, City or Town	n, State, Zip Code)
	1 and Health em 27		Thomas A. O'Brien				Avenu	e Hagersto		
Baltimore,	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1XXX Gurial 2 □ Cremation 3 □ R	lemoval from State	metery, cren	sition (Name of natory or other pla		Date		- City or Town, State
<u>=</u>	iit. Pa artmer ortant injury		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License			Cemeter			Hagerst	town,Maryland
æ	permit. Departr Importa any inju		1.9/	Ma	0s	borne Fu	ineral'	Home, P.A.	illiamen	ort,MD 21795
	Physician		23a. Perri. Enter the disease, or compli- shock, or hear failure. List only or Immediate Cause (Final disease or condition	ications that caused the death ne cause on each line.				ardiac or respiratory	arrest,	Approximate
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):	2 Live W	2 1 2	Las Ace	ident ad Co	
		-a	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ence of):	- SVOV	ason	al Acci	aren	- Tew day
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o	ate be executed obysician and the burial-transit		resulting in death) Last	Due (or as a consequ	ence of):	0	0 .			
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Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 🗌	Ectopic pregnand Other (specify)	су		1	ate of delivery lonth Day Year
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Records,	uires tha signed Id be det	d by	Hype	rlipide	m La	ragnying causa gi	voirin raiti.			3 Probably 4 Dunknown
CO	w require been significant	Completed	Ha	1124 ten	11:			24a. Was		Were autopsy findings available
	rhe lav te has age 2	omp		10-01-0	5.00.			auto	psy ormed?	prior to completion of cause of death?
ā		BeC	25. Was case referred to medical				26. Place o	1 ☐ Yes of Death (Check only	2 Z No	1 ☐ Yes 2 ②X/No
>	Physici this ce al direc	To E	examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 E	R/Outpatient	3□ DOA Ot		ing Home 5 Res		her (Specify)
Division of Vital	Attending Ph er death. ector: After th by the funeral	ertification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo M 1	nyat ork?]Yes 2 □ No		how injury occu	rred
DIVIS	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)				City or To	wn, State)	ber or Rural Route Number,
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	ledicai	one) 21 Medical Exemin	sician: To the best of my know her: On the basis of examination and manner stated.	ledge, death on and/or inv	estigation, in my	opinion, death	place, and due to the occurred at the time,	date and place,	and due to the cause(s)
)	To with	Σ	29b. Signature and title of certifier	17	-		3.54	97		ed (Month, Dey, Year) 2
1	of a		30. Name and address of person who con	KASHA MI) /	122	OPAL	CT. H	GERS	70WN MD 21790
	Sta		31. Date filed (Month, Day, Year) MAD 2. 2. 201	32. Registrar's Signatu	. Do	ester				21790

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 1- State Registrar Amended Item #10F,03/15/04 Certificate of Death CH/WCHD 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month LAURA JANE PARSONS 4:12 P M 6 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10543 Sussex RD Ocean City Worcester If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 72 Yrs 11/13/1931 Director 218-24-5958 MD Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28e-f show Exerciner roust be notified at Completed by Funeral Director 1 XYes 2 □ No Ocean City MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10543 Sussex RD 21811 21842 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be tiled within 72 hours after 0 Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural" or item any injury or other treumatic event, If a Madical Exertine ODE. 1 Never Married 2 Married 1 ☐ Yes X No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade com 16b. Kind of Business/Industry grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles David Hudson Ida Katherine Palmer 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Parsons, III 10543 Sussex RD Ocean City, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X urial 2 □ Cremation 3 □ Removal from State
'4 □ Donation 5 □ Other (Specify) Jerusalem Cemetery 3/13/04 Parsonsburg, MD 22. Name and Address of Facility The Burbage Funeral Home 21. Signatur of Fugeral Service Licensee 108 William St. Berlin, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only gneycause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) arolia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical 40015 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown nulensia 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 1 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of within 24 hours after death. To the Funerel Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Baltimore, Maryland 21215-0036

Box 68760.

P.O. |

Division of Vital Records.

State Registrar

completely

Benito S. Chan, MD 1340 S. Division St. Suite 301 Salisbury, MD 21801 31. Date filed (Month

MAR 0 9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature morrison

Nau 10

29b. Signature and title of certifier

(Check only

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

0-20052

29d. Date signed (Month, Day, Year)

			For State Registrar	State of M	laryland / Dep <i>Ce</i>	ertificate of			iene g. No. 2004	12378
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last) MARY CATHER 4a. Facility Name (If not institution, give a	RINE PO		4b. City, Town, o		2. Date of Deat Month March	h Day Year 27 2004 4c. County of Dec	4:08 AM
ı	Funeral Director	4	Genesis ElderCa 5. Social Security Number 6. Security Number 1 217-30-8766		ne Pines ge (In yrs. last birthda) 72 Yrs.		ston If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, Jan. 16, 1		bot hthplace (State or Foreign ountry) yland
- Prochage	28a-f ehow	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Talbot		10c. City, Town or U	ocation			, , , , , , , , , , , , , , , , , , ,	10d. Inside City Limits 1 A Yes 2 □ No
0036		by Funeral Dire	10e. Street and Number 210 South Stree 11. Marital Status 1 ☑Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 2 If Yes, Give Year or Dates:	Mo	10f. Zip Code 2160 Was Decedent of H If Yes, specify Cuba 1 Yes 22 No			USA 14. Race - Am Black, Wh Specify:	erican Indian,
21215-	giene. pr then "nat	Completed	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or	(Giv	edent's Usual Occup e kind of work done of DO NOT use retired e worker	during most of wo	rking	Allen Foo	s/Industry
yland	g ig S	To Be (17. Father's Name (First, Middle, Last) Phillip Overtor 19a. Informant's Name/Relationship (Ty,		19b. Mai	ing Address (Street	Mary		Maiden Sumame) Derts City or Town, State,	Zip Code)
Baltimore, M	rages I and 2 stoold thent of Heelth and Mer tant: if item 27 ie marka jury or other traumatic		Janice Brooks / Da 20a. Method of Disposition 1 Ø Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Disp cemetery, cre		θ)	Date 2	yland 2160 20c. Location - City o Frappe, Mar	r Town, State
Balti	Departm Importar eny inju		21. Signature of Foneral Service License	rinee		2. Name and Address Bennie Sm 426 Dover	is of Facility ith Fune Street,	ral Home Easton,	Maryland 2	
4	/Medical transit the burial-transit	dical Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	ine. Tration s a consequence of):	meumor -gmeel-le	rie			Interval Between Onset and Death Augs
P.O. Box 68	attending p	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year
	been signed by the s should be deteched to	ed by Ph	Part II. Other significant conditions con	tributing to death to	out not resulting in the	underlying cause give	en in Part I.			o the cause of death? robably 4 \(\subseteq Unknown
al Reco	ete has b		Anomia						ed? death? ⊠No 1 ☐ Yes	utopsy findings available completion of cause of
Division of Vital Records,	fter this	ation; To Be	27. Manner of Death Natural 5 Pending 2 Accident investigation	ospital: 1		of 28c. Injury Work	Pr: 4 Nursing H	ome 5 Resider 28d. Describe hov	nce 6 Other (Spe	icify)
Divis	nurs efter de srei Directo	Certification;	3 Suicide 6 Could not be determined	building, e	jury - At home, farm, st tc. (Specify)			City or Town,	,	
To the Hoar	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	ler: On the basis of and manner st	of my knowledge, dea of examination and/or is ated.	th occurred at the tim estigation, in my op 29c. License	inion, death occu	rred at the time, dat	use(s) and manner as te and place, and due d. Date signed (Mont	h, Day, Year)
	Sta Registr		30. Name and address of person who co Michael D. Crowl 31. Date filed (Month, Day, Year)	ey, M.D.		Print) ewild Ave.	, Eastor	,Maryland	1 21601	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** March 4:10 AM 30 2004 FRANCES M. PENTZ /Medical 4c. County of Deeth 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Genesis ElderCare -The Pines Easton Talbot If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. | 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🗓 F 85 MARYLAND Director 218-03-6779 22 1918 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. ?? Is marked other than "natural", or Items 23a or 28a-f ahow traumatic event, the Macical Examirer must be notified at 1 X Yes 2 □ No Directo EASTON TALBOT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 610 DUTCHMANS LANE 21601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🛣 No Baltimore, Maryland 21215-0036 Specify Specify: WHITE þ 3X Widowed 4 □ Divorced ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LYDIA L. PEARCE EDWARD C. MERRYMAN, JR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2212 E. BALTIMORE ST., BALTIMORE, MD 21231 ERVIN A. BROWN/PER REP. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 3-31-2004 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A.

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final Pheumonia 2 weeks Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sever-e CONS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ostea ears The law requires that the death certificate be executed 100051 attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy performed 1 🗌 Yes 2 PNo Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No I Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Russell a Selver H42587 03-30-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Russell H Schillia 555 Canwood Ar Easton m A 21601 31. Date filed (Month, Day, Year)

MAR 3 1 2004 32. Registrar's Signature State Registrar

		Item#9 per Please ir. 4/5/04 BEM 1- State AACo.Heal	State of Maryland / Deth.	Indelible Ink. Ensure A epartment of Health and I Certificate of Death	Mental Hyg	
		Decedent's Name (First, Middle, L.			2. Date of Dea	th 3. Time of Death
Physic /Medi		Deloris M.	Powel1		Month	31 2004 1055 M
Exami		4a. Facility Name (If not institution, g	ve street and number)	4b. City, Town, or Location of Deat		4c. County of Death
		Anne Arundel M	edical Center	Annapolis		Anne Arundel
Funeral			Sex 7. Age (In yrs. last birthd	Months Days Hours Min.	(Month, Day	(, Year) Country) Morery and
Director		212-40-4054 Usual Residence of Decedent	63	· _	May 2 1	940 D.C. Haryland
/land		10a. State 10b. County	10c. City, Town o	r Location		10d. Inside City Limits
the Marylan r 28a-f show	흕	Maryland Anne	Arundel Davids	onville		to the second of the second o
or 28)lre	10e. Street and Number		10f. Zip Code	1	l0g. Citizen of What Country?
d 21215-0036 filed within 72 hours efter deeth with the Maryland Hygiene. uther than "naturel", or flems 23a or 28a-f show ont, the Medical Examinar must be notified at	Funeral Director	1285 Central A		21035		USA
ier deeth w Items 23a	nue	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
Seft rs eft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Black
15-0036 72 hours eff "naturel; or	ted	15. Decedent's l	Education 16a. De	ecedent's Usual Occupation		16b. Kind of Business/Industry
215 Pin 7:	ple	(Specify only highest g	College (1-4or 5+) (G	ive kind of work done during most of wor e. DO NOT use retired)	rking	V.a. Medical Cente
21 ad wit gienne er thu	Completed	12th	4 yrs. PSY	CHIATRIC Health		
Tal Hy	Be	17. Father's Name (First, Middle, Las			•	Maiden Sumame)
Vanional Men	2	Lloyd Wil			I. Gre	
Mar 12 sh h and 7 Is m		19a. Informant's Name/Relationship April Powell-D				r, City or Town, State, Zip Code) 21035 Davidsonville, Md.
Healt em 2		20a. Method of Disposition	20b. Place of Di	sposition (Name of		20c. Location - City or Town, State
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours elt Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or any nigury or other treumetic event, the Marical Examples.		1X Burial 2 ☐ Cremation 3	cemetery, c	crematory or other place)		4 DAvidsonville, M
Iltin		' 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		22. Name and Address of Facility	1/10/0	- DAVIGSONVIIIE, P
B Per Per Per Per Per Per Per Per Per Per		Janu D.	People MADO 483		ns MOrt	uary, P.A. s, Md. 21401
Physician /Medical Examiner		shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	a. Unucaces Due to (or as a consequence of): Brain Mil	enter the mode of dying, such as cardiac Lutracrunca Loctures	or respiratory arr	est. Approximate Interval Between
68760, tificate be executed to physician and as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of): Due to (or as a consequence of):	Canel		
vision of Vital Records, P.O. Box 6876 Attending Physicien: The law requires that the death certificate to death. ector: After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months 1 □ Yes 2 ☑ No 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
rds, P quires that an signed t	by	Part II. Other significant conditions	contributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tol	oacco use contribute to the cause of death? es 2 ☑ 100 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records, to Attending Physicien: The law requires teller cleath. Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed				24a. Was a autops perform	v prior to completion of cause of
ien: Trifica	BeC	25. Was case referred to medical		26. Place of Dea	th (Check only on	
f V Iysici Is ce direc	To E	examiner? 1 Yes 2 No	Hospitat: 1 Impatient 2 ER/Outpa	tient 3 DOA Other: 4 Nursing H	ome 5 Reside	ence 6 ☐Other (Specify)
ng Pr tter tr neral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Tim-	e of 28c. Injury at		ow injury occurred
ision ttendir death. ctor: At	catle	2 Accident investigati	on	M 1 ☐ Yes 2 ☐ No		
Division Atture of the or Atture of the	Certification:	3 Suicide 6 Could not determine		street, factory, office	28f. Location (St City or Town	reet and Number or Rural Route Number, n, State)
Division of Vital Recomplete to the Hospital or Attending Physicien: The law within 24 hours effer death. To the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1	hysician: To the best of my knowledge, diminer: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	, and due to the carred at the time, d	ause(s) and manner as stated. ate and place, and due to the cause(s)
To the within 2 To the complet	Σ	29b. Signature and title of certifier	1	29c. License number		9d. Date signed (Month, Day, Year)
,		· Culi	Darin MD	053300		2/3/104
		Curtis Harn		pe, Print) stagate Ld Ste 2,	11 Ann	apolis mo 21401
St Regist	ate rar	31. Date filed (Month, Day, Year) APR 0 5	32. Registrar's Signature	Acres 11		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Norman L. Pack March 31 2004 1750 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Month, Day, Year) Anne Arundel Medical Center Anne Arundel Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1/2 M 2□F 31 1923 Maryland Director 81 721-01-4663 Jan. Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-1 show is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. It will be a 23s or 28s-1 show a 27s in marked other than "natural", or Items 23s or 28s-1 show coher traumatic event, Ite Medical Examinations Item clitical at 1 → Yes 2 □ No Director Maryland Anne Arundel Severna Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 83 W. Earleigh Heights Road

11. Marital Status

12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 21146 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married & Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) US Naval Radio 7th Maintenance Station 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Isaiah Pack <u>Sedonia Butler</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 21146 permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any injury or other traum once. Naomi Pack (Wife) 83 W. Earleigh Heights Rd. Severna Pk., 20b. Place of Disposition (Name of cometery, crematory or other place)
Asbury Town Neck Date 20c. Location - City or Town, State 20a. Method of Disposition > Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Church Cometery 1/5/01 22. Name and Address of Facility -Severna Pk Md. 21. Signature of Funeral Service Licensee Zavry A. Reese & Sons Mortuary, P.A.

821 West St. Annapolis, Md. 21 401

Approximate interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory Distress Syndrome >5d Physician /Medical Due to (or as a consequence of): 7501 **Examiner** Due to (gras a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Examine physician and s the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à lenkemin 1 Yes 2 No 3 Probably 4 Unknown Completed Diobrekey mellikes type 2 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed peripheral rese disease 1 Yes 2 No Division of Vital 25. Was c se referr to medical examiner? the funeral director, 26. Place of Death (Check only one) Hospital: 1 Appatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To this is 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funerel Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel 1 Toertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier \$/1/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolis med 21401 AAMC choit 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 5 2004 Registrar

Amend Item//5 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For pper Phy. 4/8/04 State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 State Registrar AACo. Health Dept. BEM Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Mary E. Peters /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North Arundel Hospital Glen Burnie Anne Arundel 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Yrs. Director 216-60-5168 88 12 1915 Maryland Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d, Inside City Limits If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examinal must be notified at 1 TYes 2 No Directo Odenton Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with COULT

12. Was Decedent Ever in U.S. Armed Forces?
1 | Yes 20 No If Yes, Give Year or Dates: Completed by Funeral 21113 523 Stone Hill USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. om 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) 9th Housewife None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Unobtainable Alverta Freeland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tran 5730 Shady Side Rd. Churchton, Md. Caroline Holland (Daughter) 20733 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hill Crest Cemetery 4/6/04 Annapolis, Md. 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Zavy 4. Reese Sons Mortuary, P.A.

821 WFst St. Annapolis, Md. 21101

23a. Part1. Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to by as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last Due to (or às à consequence of). Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medicai for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 TYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29c. License number 29b. Signature and title of certifier MDName and address of person who completed cause of death (Item 23g) (Type Print) 31. Date filed (Month, Day, Year) State **APR 08** 2004 Registrar

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State Registrar

Baltimore, Maryland 21215-0036

579-12-6773

Gladys Parks

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

30. Name and address of Person who empleted cause of death (Item 23a) (Type, Print)

David Secnler, M.D. 145 E. Carroll

31. Date filed (Month, Day, Year)

32. Registrar's Signature

APR 0 2 2004 | Eleven

145 E. Carroll St

Salisbury, mD

State of Maryland / Department of Health and Mental Hygiene, 004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2004 Pearce April 8:50 pm Genevieve /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Calvert Manor Rising Sun If Under 1 Year If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 🗓 F Aug 10 1914 Philadelphia PA 89 Director 163-10-1628 Usual Besidence of Decedent permit. Peges 1 and 2 should be filed within 72 hours aftar death with the Manyland Department of Health and Mental Hygiene. Important: If ten 23 er 28ef show any propriant: If ten 27 is marked other than "natural", or itema 23e or 28ef show any Injury or other traumatic event, in a Medical Examiner mant be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21911 1881 Telegraph Road USA Funeral 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2**X**XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yas 2KXIo Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Unknown) Mary (nee: unknown) Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 300 Sparta Court Bel Air, MD <u>Maureen H. North</u> 20b. Place of Disposition (Name of cometery, crematory, or other place)
Loly, Sepulchre
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Apr 2004 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chandler Funeral Home 2506 Concord Pike Wilmington, DE 19803 Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical 3 years Examiner Examine or Attending Physicien; The law requires that the death certificate be assoluted ettending physician end I for use es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 XNo 3 Probably 4 Unknown δ been si 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? s cartificate has b 1 Yes 2 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Lursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 ☐ Pending 1 Tyes 2 TNo heral Director; A investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗆 Homicide To the Hospital within 24 hours e To the Funeral C completaly fillad TECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 4/2/04 200048050 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 South Parke St. #400 Aberdeen MD 21001 Prashant MO Shukla 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Day Year

Exami Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or hems 23a or 28a-f show any joury or other treumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and bompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Physicia		Paulin	e H. Par	ks					March 2	4, Day 2004	Year 1	12:27 PM
/Medic		4a. Facility Name (If not institution, gi	ve street end nu	mber)			4b. City, Town, or Le	ocation of Death	4c. County	of Deeth	
	٠.	Manor Ca	re Chevy	Chase				Chevy Ch	ase	Mont	gomery	
uneral irector		5. Social Security N 579-49-84	1	Sex 1□M 2XTF	7. Age (In yrs. 85	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, NOV • 2,	^r 1918	9. Birthplac Country Vashin	gton, DC
		Usual Residence o	1		100 00						404	Landa On Line
Show	_	10a. State	10b. County			y, Town or Lo					100.	. Inside City Limits 1X Yes 2 □ No
8a-f	윷	D.C.	N/A		Was	hingto						
2 2	ä	10e. Street and Nu					10f. Zip Code			g. Citizen of V		
238 Aust	Funeral Director		nn Stree				20009			United		
te a	Ę.	11. Marital Status	ted OF Mented	Armed Fo			was Decedent of If Yes, specify Cub	Hispanic Origin? (Sp oan, Mexican, Puerto	ecity Yes or No- Rican, etc.)		e - American ck, White, etc	
0 0	by F	1 ☐ Never Marr 3 ☐ Widowed	ied 2 Married 4 Divorced	1 ☐ Yes If Yes, Giv Year or D	/e		1□Yes 2XDNo	Specify:		Specify	ian Am	erican
Department or result and wenter rigiding. Department or result and wenter rigiding in the ms 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.			15. Decedent's E		4100.	16a. Dece	dent's Usual Occu	pation	11	6b. Kind of Bu		
e une	Completed		cify only highest gi	ade completed)	1.404.51)	(Give	kind of work done DO NOT use retire	during most of work	ring			
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ent,	Be C	17. Father's Name	(First, Middle, Las	t)				18. Mother's Nam	e (First, Middle, M	laiden Sumem	10)	
ked ic ev	10 B	Thorton	C. Hart					Clara B	ell Daver	nport		
a La		19a. Informant's Na	ame/Relationship	(Type, Print)		19b. Mailir	ng Address (Stree	t and Number or Run	al Route Number,	City or Town,	State, Zip Co	ode)
27 is		Renee' H	P. Davis	(daugh	ter)	6716	Good Luc	k Road, L	anham, M	D 2070)6	
othe		20a. Method of Dis				Place of Dispo	sition (Name of metory or other ple	ece)		Oc. Location -	City or Town	, Stete
4 2 5			☐ Cremation 3 [5 ☐ Other (Spec		State	· .		Cemetery	3/31/04	Suitlar	nd, Ma	ryland
inju	- Î	21. Signature of Fu	ineral Service Lice	insee		22	2. Name and Addr	ess of FacilityMcG				
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/sician		shock, or hea	irt failure. List only	one cause on e							Int Or	terval Between nset and Death
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aminer		disease or condition resulting in death)	on	a		or as a consec	mence of).				1	
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he al	Sic	Pert II. Other signif	icant conditions	contributing to de	eath but not resi	ulting in the u	nderlying cause gi	iven in Part I.	23b. Did tob	acco use cor	tribute to th	e ceuse of deeth?
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After	<u>ö</u>	27. Manner of Deet 1 ☑ Natural	5 Pending		th, Day Year)	28b. Time of Injury	Wo	ork?]Yes 2□No	28d. Describe how	winjury occurr	eu	
tor:	icat	2 ☐ Accident 3 ☐ Suicide	investigation 6 ☐ Could not I	OB Place	of Injuny - At he	omo farm etr	eet, factory, office		28f. Location (Stre	eet and Numb	er or Rural Ro	oute Number
Direction by	Certification:	4 ☐ Homicide	determined	buildi	ng, etc. (Specif	y)	eet, factory, office		City or Town,		or or ribiarri	Julio Ivambor,
filled		29a. Certifier	Certifying P	hysicien: To the	hest of my know	wiedge death	occurred at the ti	ime, date and place,	and due to the car	ise(s) and ma	nner es state	id
Fun	edicai	(Check only one)	2☐ Medical Exe	miner: On the ba	asis of examination	tion and/or inv	estigation, in my	opinion, death occurr	ed at the time, da	te and place, a	and due to the	a cause(s)
To the Funeral Director: After this certificate has been signed by Completely filled in by the funeral director, page 2 should be detacted.	Me	29b. Signature and	title of certifier		1		29c. Licen	se number	29	d. Date signed	(Month, Dey	/, Year)
/		▶ /k	- SPANII	an Lu	ndan	/	DS	3367	^	1ARCH	243	, 2004.
>		30. Name and addr	2 40091	70.00		1 23a) (Type.	Print) Shyam	Garthy	ASM, HIS.		1 200	78.
		10810	DAMAIN	mun.	Road	Cimil	i 202.	yanth	MONG	1, OVIL	1 208	70'
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Registra		MA	R 29 20	U4 🔎	greener	S	pouls					

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>004</u> Physician CONSTANCE MARCH 24 8 30 A. PERCY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY 11801 ROCKVILLE PIKE, #511 ROCKVILLE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 ☐ M 2 🗓 F Hours 89 Director 132-07-1298 OCT 20, 1914 NEW YORK Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits r than "natural", or items 23s or 28a-f show the Medical Examinar must be notified at 1 ☐Yes 2 ☐ No Directo ROCKVILLE MARYLAND MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 11801 ROCKVILLE PIKE, #511 UNITED STATES Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ☐Yes 2 7 No Yes, Give X Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: þ 3 ₩ Widowed 4 Divorced Year or Dates: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) **BIO-STATISTICIAN** 5+ GOVERNMENT 12 should be filed w h and Mental Hygier 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LEBAIR LUCILE MORDECAI ဂ HAROLD Α. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s tment of Health an tant: If item 27 Is jury or other trau 5160 DARTING BIRD LN., COLUMBIA, MD 21044 CONNIE AARONSON, DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【**XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Pages
Department of
Important: If it
any injury or o COMFORT CREMATORY 3/25/2004 ALEXANDRIA, VIRGINIA 21. Sign ture of Fune at 3 rvic | ice see 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE ROCKVILLE, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 1 YEAR LYMPHOMA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last was to (or as a consequence of) burial-transit Exami attending physician and Due to (or as a consequence of) Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death the 9 Unknown The law requires that the 9 Unknown been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy 1 ☐ Yes 2 XNo or Attending Physicien: the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 XNo 2 3 DOA 4 ☐ Nursing Home 5 XResidence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury Certification: 28d. Describe how injury occurred after death. Director: After 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. Vithin 2 29c. License number 29d. Date signed (Month, Day, Year) D32407 10 MARCH 24: 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH M. HAGGERTY 9707 MEDICAL CENTER DRIVE, #300 ROCKVILLE M.D. MD 20850 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 29 2004 MAR

3/24/2004

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	'Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Marie Antoinette Porter 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of Death	March 27	4c. County of Death	8:30 PM
	Lxqiiiii		Springbrook Adventist Nursi		Silve	er Spring		Montgome	
P	Funeral Director		1 D N 2 1 2 1	(In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y) Mar. 22,	9. Birth Cou	place (State or Foreign ntry)
	ס		Usual Residence of Decedent				Mar. 22,		ginia
	show	or		0c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28a-i	rect	Maryland Montgomery 10e. Street and Number	Silver :	Spring 10f. Zip Code		10g	. Citizen of What Cou	
	ath with	Funerai Director	12325 New Hampshire Avenue		20904			USA	
	Items	-une	11. Marital Status 1 ☐ Never Married 2 ☐ Married 12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No	er in U.S. 13. V	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
900	ral', or	by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	1	1 ☐ Yes 2 ☑ No	Specify:		Specify: Blac	ck
Maryland 21215-0036	tiled within 72 hours atter death with the Maryland Hygiene. titler than "natural", or Items 23c or 28a-1 show titler than "natural", or Items 13c or 28a-1 show ant, I're Medical Exercit as remain the medified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	tent's Usual Occupa kind of work done of DO NOT use retired	durina most of workir	16	b. Kind of Business/Ir	ndustry
72	iene. r than	omp	Elementary/Secondary (0-12) College (1-4or 5+)	1		" Lon & Payment	: Specialis		al & District
pg	be filed tal Hyg d othe avant,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name			eriments
Z	d Meni narka netic	To	William Fisher Granger 19a. Informant's Name/Relationship (Type, Print)		Address (Street		Richard	SON City or Town, State, Zip	- Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28a-f show among injury go other traumetic avant, If a Medical Ever item in at the notified at angle.		Lois R. Goodman/ Guardian	5550				ington, DC	en a voteses
Baltimore,	es 1 a of Hea fitam frothe		20a. Method of Disposition	20b. Place of Dispos cemetery, cren	sition (Name of natory or other plac	D	ate 20	c. Location · City or To	own, State
<u>Ē</u>	tment rant: I		* 4 ☐ Donation 5 ☐ Other (Specify)	Gate of H	ery	20		lver Sprin	g. MO
Ba	permi Depa Impo any ir		21. Signature of Funeral Service Licensee	Fra		Collins F			
ľ	.#		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do not ente	or the mode of dyin	g, such as cardiac o	respiratory arrest	ver Sprine	Approximate
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	/Medical Examiner			consequence of):					
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	cate be executed oblysician and the burial-transit	Examiner	that initiated events						
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မ	tificate ng phy as the	Medic	US 550.W.5						
Box	The law requires that the death certifical the has been signed by the attending places and a second for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of 1 □ Live birth 2	Fetal death 3	Ectopic pregnancy			23d. Date of deliver	ery Day Year
P.0.	at the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	ne of death 5	Other (specify)				
	res that signed b be deta	by PI	Part II. Other significant conditions contributing to death but	_		en in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
ord	w require	eted	Demention Hypert				1 🗆 Yes	2 No 3 Prob	oably 4 Unknown
Red	The law ate has page 2 s	Completed	Deep Vein Thro	m bos	<i>is</i>		24a. Was an autopsy performed	prior to co	psy findings available mpletion of cause of
Vital Records,		0	25. Was case referred to medical			26. Place of Death	1 ☐ Yes 2 ₹ (Check only one)	No 1 □ Yes	2□ No
> <	di S	To B		2 ER/Outpatient		er: 4 Nursing Hom	e 5 Residenc	e 6 □Other (Specif	y)
Division of	ding P h. After i funera	tion:	27. Manner of Death 1 ■ Natural 5 □ Pending (Month, Day Y	ear) 28b. Time of Injury	28c. Injury Work M 1 🗆	/ at 2 <br Yes 2 □ No	8d. Describe how	injury occurred	
NISI N	Attending Ph er death. ractor: After th by the funeral	Certification:	3□ Suiside 6□ Could not be	- At home, farm, stre			8f. Location (Stree City or Town, S	t and Number or Rura	I Route Number,
	Hospital or Attanding I 24 hours after death. Funaral Diractor: After tely filled in by the funer								
	To tha Hospital or within 24 hours after To tha Funaral Dir. completely filled in I	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of control of the basis of examiner: On the basis of examiner state	camination and/or inv	occurred at the time restigation, in my op	ne, date and place, a pinion, death occurre	nd due to the caus d at the time, date	e(s) and manner as si and place, and due to	tated. the cause(s)
	To tha within 2 To tha complet	Me	29b. Signature and the objectifies		29c. License			Date signed (Month,	
)	(0		fut the			31001	_	3/29/0	4
	•		30. Name and address of person who comply fause of deal Stroart T. Turkenes 1 2 31. Date filed (Month Day Year) 32. Registrat's	th (Item 23a) (Type, I	Print) 7500	enbelt.	MD. 20	oter. Dr.	7430
	Sta		31. Date filed (Month, Day, Year) MAR 3 1 2004 32. Begistrar's		Boorda			- •	
	Registr	वा	MILLIN OT COOL	100	hadron contractor				

			For State Registrar	State of N		artment of F		nd Mental Hygie	ene	19200
			Decedent's Name (First, Midd	dle, Last)				2. Date of Death	0.0	3. Time of Death
	Physici /Medic		Donald	Lee	Perro	tt		Month	31, 2004	9:39 PM
	Examin		4a. Facility Name (If not institution	on, give street and numbe		4b. City, Town, o	or Location of	Death	4c. County of Death	
			Washington Cou	unty Hospita	1	Hagersto	own		Washingto	n
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last birthday,	If Under 1 Year	If Under 24			place (State or Foreign
	Director		220-34-2211	1 ∑ M 2□F	65 Yrs.	Months Days	Hours	July 24.	1938 Mary	
	D.		Usual Residence of Decedent							
	show		10a. State 10b. Count	У	10c. City, Town or L	ocation			1	Od. Inside City Limits
	e Ma Sa-f	cto	MD Wash:	ington	Hagersto	wn				1 X Yes 2 □ No
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show fre Modeal Examilier chast by motified at	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Cour	ntry?
	23a	a	7 E. Washingto	n St. Apt.6	11	21740)		U.S.A.	
	after des or Itams	Funerai	11. Marital Status	12. Was Decede Armed Force	ont Ever in U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origii an, Mexican, I	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Americ Black, White,	
36	or It	Ŋ.	1 XNever Married 2 ☐ Ma	If Yes, Give	X No	1 ☐ Yes 2X No			Specific	
21215-0036	"natural", o	d by	3 Widowed 4 Divorce		s:				Whi	te
7	nat "nat	Completed	15. Decede (Specify only high	nt's Education est grade completed)	(Give	dent's Usual Occup kind of work done	durina most o	of working	ib. Kind of Business/In	dustry
12	vithir ne. han	m D	Elementary/Secondary (0-12)	College (1-4d	or 5+)	DO NOT use retire	<i>a)</i>		27 / 4	
2	be filed within 72 ho ital Hygiene. id othar than "natui evant, II's Modical		17. Father's Name (First, Middle	/ act)		Disabled	10 Mathad	a bloom a /Circh blistation blas	N/A	
Maryland		Be						s Name (First, Middle, Ma	iden Sumame)	
ž	d 2 should th and Men 7 Is marka traumatic	۴	Alexander J. P 19a. Informant's Name/Relation		405 14.33			lie Miller		
Ma	12 ha							or Rural Route Number, C		Code)
Т	s 1 and 2 f Health itam 27 l		William Perrot 20a. Method of Disposition	t/Brotner	20h Place of Dispo	Carrotton	Ave.	Hagerstown,		Chan
ō	of of		1 X Burial 2 ☐ Cremation	3 □Removal from Sta				Date 20	c. Location - City or To	own, State
Ei Ti	tant:		`4 Donation 5 Other (Rest Hav			5/2004 Ha	agerstown,	MD
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	a Licensee		2. Name and Addre		Rest Haven	Funeral Ch	ape1
	005 e d		Stephen (V ha	4C Jum	10	601 Penns	ylvani	a Ave. Hageı	cstown, MD	21742
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cause it only one cause on each	sed the death. Do not en n tine.	ter the mode of dyir	ng, such as ca		0	Approximate Interval Between
	Pnysician	0 9	Immediate Cause (Final disease or condition	Dia	betic 1	(xphro(cany	causing	Renad	Onset and Death
	/Medical		resulting in death)	Due to (or	as a consequence of):		1 0		tailare	
	Examiner		Sapunnially list conditions		abetis_	Will	tus		400	
	D ##	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	4	as a consequence of):	(. V	Arar	t Failu	x e	
	and and trans	Examin	that initiated events resulting in death) Last	c	ngasti	7 6	7 6 61	1 8 0011.		
8760,	the death certificate be executed y the attending physician and iched for use as the burial-transit		resulting in death) cast	Due to (or a	as a entrequence of):					
876	ate b hysic the b	dical		d						
9	leath certific attending pl	Mec	IF FEMALE:							
Вох	ath ce ttend or us	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon 1 ☐ Live birth		Ectopic pregnancy	,		23d. Date of delive Month	,
0.	e de	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant 9☐Unknown		Other (specify)			MOILI	Day Year
P.	that the de	Phy								
	se Ded	by	Part II. Other significant condit	ions contributing to death	n but not resulting in the u	nderlying cause giv	en in Part I.		cco use contribute to th	
orc	w requir been si should	ted						1 ☐ Yes	2 □ No 3 □ Prob	ably 4 □Unknown
Vital Records,	e taw i has bo	Completed						24a. Was an autopsy	24b. Were autop	osy findings available appletion of cause of
H	The tate has page	on						performed 1 ☐ Yes 2	death?	2 No
ita	Physician: The this certificate ral director, pag	Be (25. Was case referred to medic	al			26. Place of	Death Check onl one		
>	S 0 =	70	examiner? 1 Tes 2 No	Hospital: 1 Inpa	atient 2 ER/Outpatier	nt 3□ DOA Oth	er: 4 🗆 Nursi	ng Home 5 Residence	e 6 Other (Specify	•)
υor			27. Manner of Death 1 ☐ Natural 5 ☐ Pendi	28a. Date of Ir (Month, I	njury 28b. Time o Day Year) Injury	f 28c. Injur Wor	v at	28d. Describe how		
<u>ō</u>	Attanding r death. actor: After by the fune	atic	2 ☐ Accident invest	tigation	,,		Yes 2 □ No			
Division	after death after death Diractor: I in by the	tific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	minod 286. Place 01	Injury - At home, farm, stretc. (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	at and Number or Rura	Route Number,
	tal or A s after al Dirac ed in by	Certification:						ony or rount, c	, iaio)	
	To the Hospitel or Attentwithin 24 hours after deati To the Funaral Director: completely filled in by the	<u>60</u>	29a. Certifier 1 Certifyi	ing Physician: To the beat fexaminer: On the basis	st of my knowledge, deat	n occurred at the tin	ne, date and p	place, and due to the caus	se(s) and manner as st	ated.
	ha H in 24 he F plete	edica	one)	and manner	stated.	vestigation, in my o	pinion, death	occurred at the time, date	and place, and due to	the cause(s)
	To the Hospital within 24 hours a To the Funeral t completely filled	Σ	29b. Signature and title of certifi	er		29c. Licens			Date signed (Month, L	
ŧ			- farm	vumer!		000	603	36	04/01/04	ì
5	433		30. Name and address of person	m who completed cause of MURSHE	of death (Item 23a) (Type,			ert Has	md	
	Sta Registr		31. Date filed (Month, Pay, Year APR 0	2 2004 32. Pegis	of death (Item 23a) (Type, D)	aks		1, 7		

			For State Registrar	State of M	Maryland /		ent of F		and M	1.00	ene 200	4 12389
			1. Decedent's Name (First, Middle, L		1					2. Date of Death Month		3. Time of Death
	Physici /Medic		program	x P	rehn					April	Day Yea	M
7	Examin		4a. Facility Name (If not institution, gr		er)	4b. (City, Town, or	r Location o	f Death		4c. County of D	eath
			781 Robin Hood 5. Social Security Number 6.	Hill Sex 7.	Age (In yrs. last bi	irthday) If U	Sherwoo	od For	rest	8. Date of Birth	Anne Ai	
	Funeral Director			1□M 20F	78	Yrs. Mon		Hours	Min.	(Month, Day, Y	(ear) 7, 1926	Birthplace (State or Foreign Country) Missouri
	pu ,		495-20-3945 Usual Residence of Decedent							nam- Zi	1940	
	be filed within 72 hours after death with the Maryland at Hygiene. All Hygiene. All Hygiene. event. It a Medical Examinat must be notified at	2	10a. State 10b. County		10c. City, Tov							10d. fnside City Limits 1 ☐ Yes 2 ➡No
	28a-f	Director	Maryland Anne A 10e. Street and Number	rundel	Anna	polis	. Zip Code			100	. Citizen of What	07-1
	3a or	i		_		100						
	death ms 2	Jera	800 Bestgate Roa 11. Marital Status	12. Was Deceder	nt Ever in U.S.	13. Was D	21401 ecedent of H	ispanic Orig	in? (Spec	cify Yes or No- lican, etc.)		merican Indian,
9	after or ite	by Funerai	1 Never Married 2 Married	Armed Force 1 Tes 2			specify Cuba os 2 1 No	sn, Mexican, Specify:	, Puerto F	lican, etc.)	Black, W	hite, etc.
21215-0036	ural',		3 Widowed 4 Divorced	Year or Dates	s:		IIII					white
15-	n 72 nat	Completed	15. Decedent's E (Specify only highest g	rade completed)		i. Decedent's (Give kind of life DO NO	Usual Occupa f work done d Tuse retired	ation during most	of workin	g 16	ib. Kind of Busine	ss/Industry
212	filed with Hygiene. ther than	omp	Elementary/Secondary (0-12)	College (1-4d	or 5+)			7			hooni to I	
פ	e filed al Hyg othe vent.	Be C	17. Father's Name (First, Middle, Las			nui	.50	18. Mother	's Name	(First, Middle, Ma	hospital	
Vlai	2 should be f and Mental I is marked of aumatic eve	To	Tom Dye					Made	elin	Fischer		
Maryland	d 2 should th and Mer 17 is marke traumatic		19a. Informant's Name/Relationship	(Type, Print)	198	b. Mailing Add	ress (Street a	and Number	r or Rural	Route Number, C	City or Town, State	e, Zip Code)
	s 1 and 2 f Health item 27 other tra	3	John Prehn/ husb 20a. Method of Disposition	and	80 Blace 6	00 Best	gate I	Road A		olis, M		
Baltimore,			1 Burial 2 Cremation 3	☐Removal from Sta		ery, crematory	or other plac	1			c. Location - City	
틆	E 48 -3		* 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		Metro	Cremat			1/8/0		ltimore,	mD
Ba	Departi Departi Import eny inj once.	Ų,	12 Soft	Romini	Slie	147	Duke o	of Glo	ouces	n M. Tay ter St.	nnapoli Annapoli	eral Home, Ind s, MD 21401
П			23a. Part1. Enter the disease, or cor shock, or heart faifure. List only	one cause on each	ed the death. Do							Approximate Interval Between
100	Physician		Immediate Cause (Final disease or condition		parki	200	's c	disc	930			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	s a consequence	<u> </u>						33011
ý	8 K.	<u></u>	Sequentially list conditions,	b								
	pet list	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dae 10 (01 8	sa consaquenca	ory.						
,	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or a	as a consequence	of);						
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9	The law requires that the death certificate the has been signed by the attending phy bage 2 should be detached for use as the	Medi	IF FEMALE:							111		
Вох	ath ce ttendi	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	ne of pregnancy 2 Petal death	n 3 ⊟Ectop	ic pregnancy				23d. Date of c	
0.	at the dea by the a tached for	ysic	1 Yes 2 No	4☐ Pregnant 9☐ Unknown	at time of death	5 🗌 Other	(specify)				Month	Day Year
ď	that the od by detac		Part II. Other significant conditions	contributing to death	but not resulting i	n the underlyi	nd cause dive	en in Part I.		23e. Did tobac	co use contribute	to the cause of death?
Records,	vires signi	d by			· ·		3 3 -				2 □ No 3 □	
00	w requir	Completed								24a. Was an	24h Were	autopsy findings available
Re	The tav ate has page 2	omp							_	autopsy performed	d? prior to	o completion of cause of
		BeC	25. Was case referred to medical					26. Place o	of Death /	1 Yes 2 Check only one)	1 □ Yı	s 2⊡No Son's
of V	8 S E	To E	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpa	tient 2 ☐ ER/Ou	utpatient 3	DOA Othe	200		9 5 ☐ Residenc	e 6 Other (Sp	
	ding Phy h. After thi funeral o		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, D		Time of Injury	28c. Injury Work	at ?	28	d. Describe how	injury occurred	
Division	Attending r death. ector: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be	30		М		res 2□N				
			4 Homicide determined	289. Place of I	njury - At home, fa etc. <i>(Specify)</i>	arm, street, fac	tory, office		28	f. Location (Stree City or Town, S	et and Number or i State)	Rural Route Number,
á	or Dir.	ertifi				a death occur	red at the tim	e date and	place, an	d due to the caus	e(s) and manner	as stated.
á	or Dir.	al Certification:	29a. Certifier 1 Cartifying P	hysician: To the bes	st of my knowledge	o, doain occur					-(-)	
ă	or Dir.		29a. Certifier 1 Cartifying P (Check only one) 2 Medical Exa	hysician: To the bes miner: On the basis and manner:	or examination an	id/or investiga	tion, in my op	pinion, death	occurred	at the time, date	and place, and di	ue to the cause(s)
Ö	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	Medical Certifi	(Check Only 2 Medical Exa	miner: On the basis	or examination an	d/or investiga	tion, in my op	oinion, death	occurred	at the time, date	Date signed (Mon	ue to the cause(s)
Ö	or Dir.	edical	one)	miner: On the basis	or examination an	nd/or investiga	tion, in my op	oinion, death	occurred	at the time, date		ue to the cause(s)
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Ö	To the Hospital or within 24 hours after To the Funest or Completely filled in I	Medical	29b. Signature and the of certifier 30. Name and address of person who	completed cause of	of examination and stated.	ovor investiga	29c. License	oinion, death)	29d.	Date signed (Mo	nth, Day, Year)
Ö	or Dir.	Medical	29b. Signature and address of person who 30. Name and address of person who 31. Date filed (Month, Day, Year)	completed cause of	or examination an stated.	(Type, Print)	29c. License	number)	29d.	Date signed (Mo	nth, Day, Year)

ORIGINAL

			1 - For State Registrar	State of Man	/land / Dep	partment of ertificate of		ental Hygiei Reg.	ne No. 2004 239
	Physici /Medi		1. Decedent's Name (First, Middle, La ROBERT H. ROSS	5				MARCH	3. Time of Death 5, 2004 9:00 AM
	Examir	ner	4a. Fecility Name (If not institution, gir			4b. City, Town,	or Location of Death		4c. County of Death
	F		Salisbury Nursing 5. Social Security Number 6.		enter n yrs. last birthdaj	v) If Under 1 Year	Salisbury If Under 24 Hrs.	9 Date of Birth	Wicomico 9. Birthplace (State or Foreign
	Funeral Director				59 Yrs.	Months Days	Hours Min.	(Month, Day, Ye Feb. 19	ar) '45 Virginia
	death with the Maryland ms 23s or 28e-f show Frrust be notified at	ŏ	10a. State 10b. County		Oc. City, Town or I				10d. Inside City Limits 1 ☐ Yes ※ No
	th the N or 28e-i	Funeral Director	MD Worces 1 10e. Street and Number	ter	Girdlet	10f. Zip Code		10g.	Citizen of What Country?
	ath wi	la [P.O. Box 93			21829		Ţ	JSA
036	e = =	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 X Yes 2 \(\text{No.} \) If Yes, Give \(\text{Nat.} \) Year or Dates: \(\text{C} \)		. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Spec an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	nin 72 ho in "natur Medicul	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation	16a. Dec	edent's Usual Occu re kind of work done DO NOT use retire	during most of workin	16b	Kind of Business/Industry
213	d with	E O	9	College (1-401 5+)	cler	k		gro	ocery
ROBERT ROSS Baltimore, Maryland	uld be file Aental Hy rked oth tic event	To Be (17. Father's Name (First, Middle, Last Ralph R. Ross	")			18. Mother's Name Celeste		,
ROSS	nd 2 sho lith and N 27 is me treuma		19a. Informant's Name/Relationship Celeste J. Kour						y or Town, State, Zip Code) othwyn , PA 19061
ROBERT timore.	s 1 ar f Hea item		20a. Method of Disposition	2		position (Name of ematory or other pla			Location - City or Town, State
OB I	Page nent o ant: If Iry or		1 ☐ Burial 2 🛱 Cremation 3 [`4 ☐ Donation 5 ☐ Other (Speci	Themoval nom State		Cremato:		004 Sa	lisbury,MD
Ralti	permit. Departr Importe any inju		21 Signature of Fulf all Service Lice		H	22. Name and Addr.	elson Fune	eral Home	
8760.	Attending Physicien: The law requires that the death certificate be executed to the factor. After this certificate has been signed by the attending physician and map of the funeral director, page 2 should be detached for use as the burial-transit to be a signed by the funeral director.	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		onsequence of):				Interval Between Onset and Death
P.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Med	iF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnanc	у		23d. Date of delivery Month Day Year
	w requires that been signed b	by	Part II. Other significant conditions	contributing to death but no	ot resulting in the	underlying cause gr	ven in Part I.	23e. Did tobacco	o use contribute to the cause of death?
Division of Vital Records.	ysicien: The law re is certificate has be director, page 2 sho	Completed						24a. Was an autopsy performed?	
Vita	icien: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Death		
on of	ding Phys h. After this funeral dir	lon: To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	2 ER/Outpatie 28b. Time (ar)	of 28c. Injur		e 5 Residence	
Divisio	afte Dir	Certification:	2 Accident investigatio 3 Suicide 6 Could not be 4 Homicide determined	On Disease (Initial	At home, farm, si pecify)		Yes 2 No	Bf. Location (Street and City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical (29a. Certifier 1 ☐ Certifying Pl (Check only one) 2 ☐ Medical Exam	nysician: To the best of miner: On the basis of exa and manner stated.	y knowledge, dea imination and/or i	th occurred at the timestigation, in my convestigation, in my converting the state of the state	me, date and place, an pinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier			29c. Licens			ate signed (Month, Day, Year)
U ,	2 11		> strace	- M-D	-	D	29168	3	15/00
. /	2.H. ratis		30. Name and address of person who				ivision St	.Suite,Sa	lisbury, Md.21804
. ~	Sta	te	31. Date filed (Month, Day, Year)	32. Hegistrar's		barde			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** RIGSBY HUGH FRANCIS 1236 MARCH 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PENINSULA REGIONAL SAL1364M HICOMICO Medical CONTO If Under 1 Year If Upder 24 Hrs. 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1**№** M 2□F 75 494-22-4261 MO. 9-22-28 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Worcester Ocean City Md. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 609 Bayshore Drive 21842 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinent of Health and Mental Hygiene.
Int: If itam 27 is marked other than Copy Machines Salesman 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Glenn Rigsby Belva Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Ann Rigsby/Spouse 609 Bayshore Drive OCean City, MD. 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) ö permit. Page Department of Important: If any injury or once. 3 - 5 - 04Salisbury, MD. Salisbury Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Pin1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ullrich Funeral Home Berlin, MD. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) STENOSIS NTIC **Physician** MONTAS /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ò in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) be detached 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 Zunknown 1 ☐ Yes 2 ☐ No page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed: 1 ☐ Yes 2 Ø No 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the hours after deat uneral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3-4-04

DHMH 17 Rev 1/2001

State

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Eastern Shore Dr.

md. 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Desmarais

9 2004

ene

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Maryland	d / Depa		lealth and		-	12392
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last) Howard 4a. Facility Name (If not institution, give s	RUARL treet and number)		4b. City, Town, c	or Location of De	2. Date of Death Month MCVCh	Day Year 2504	3. Time of Death 2320 7°M
	Funeral Director	M -	Northwest Hospital 5. Social Security Number 216-16-7447 Usuet Residence of Decedent	Center M 2□F 7. Age (In yrs. I. 80	ast birthday) Yrs.	Randa11 If Under 1 Year Months Days	If Under 24 H	8. Date of Birth (Month, Day, May 23,	Baltimore (ear) 9. Bir	e thplace (State or Foreign ountry) yland
	ith the Maryland or 28a-f show	Director	10a. State 10b. County MD Baltimore 10e. Street and Number		. Town or Lo			10	g. Citizen of What Co	10d. Inside City Limits 1 Yes 2 No
036	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "netural", or itams 23a or 28a-f show avent, the Medical Examinal must be notified at	by Funerai	10221 Harvest Fiel 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	ds Drive 2. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 M No If Yes, Give Year or Dates:		21163 Was Decedent of to the total Yes, specify Cub		(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	erican Indian, te, etc.
Maryland 21215-0036	filed within 72 ho Hygiene other then "netur ent, the Wedical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		(Give life. L	dent's Usual Occup kind of work done DO NOT use retire ical Cont	during most of w d) rol Pro	vorking	artin Mar	
ıryland	d 2 should be f th and Mental b 7 Is marked of traumatic ave	To Be	Howard C. Ruark, S 19a. Informant's Name/Relationship (Type		19b. Mailin	ng Address (Street	Thedti	S I. Jones Rural Route Number, (·	Zin Code)
	1 and Health tem 27 other tr			Wife	10221		Fields	Drive Wood		21163
Baltimore,	Page ent c nt: # ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Dogation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Dru	id Rid	lge Cemet . Name and Addre	ery 20	cch 29,	.kesville,	
Ba	permit. I Departm Importer any inju		23a. Fart1. E ter the disease, or complic	any	Bu 12	rrier-Qu 12 W. Ol	een Fund d Libert	eral Direct y Road Wi		D 21784 Approximate
/60,	Physician / Medical Examiner strength of the private s	lical Examiner	hock, o heart failure. List only one immediate Cause (Finat dis-ase or condition resulting in leath) Sequentially list conditions, if any, leading to immediate cause. Enter underrying Cause (Disease or injury that inflated events resulting in death) Last d. d.	Due to (or as a consequence to (or a))).	OA e of):	nær				Interval Batween Onset and Death
.O. Box 68	death certif e attending od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of deli Month	ivery Day Year
rds, P	w requires that the dibeen signed by the should be detached	by	Part II. Dther significant conditions cont	ributing to death but not resu	lting in the un	derlying cause giv	en in Part I.		cco use contribute to	the cause of death?
	The lar ate has page 2	e Completed	25. Was case referred to medical				26 Place of D		d2 prior to death?	itopsy findings available completion of cause of
ō	ding Phy h. After this funeral d	ToB	examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1	FvOutpatient 28b. Time of Injury	28c, Injur Wor	er: 4 🗍 Nursing	eath Check on one Home 5 Residence 28d. Describe how		afy)
=	A 79 Q	i Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)				City or Town, S	,	
	To the Hospitel or within 24 hours after to the Funerel Dir completely filled in	Medicai	29a. Certifier (Check only one) 2□ Medical Examina 29b. Signature and title of certifier	cian: To the best of my know er: On the basis of examinati and manner stated.	on and/or inv	estigation, in my o	pinion, death oc	curred at the time, date	se(s) and manner as and place, and due Date signed (Month	to the cause(s)
(IEUS I	ŀ	30. Name and address of ten on who con	npleted cause of death (Item	23a) (Type _a F	H005	1339	W	buch 23	>,200f
	Sta	50	31. Date filed (Month, Day, Year)	1000 540) (32. Registrar's Signatu	Id Ct	Rel. Ka	volcellst	owy MD	2/133	
Α.	Registr	ar	MAR 2 6 2	004 Kleene	15 /	boute				

			State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 2004 12393
g sites	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) HONEYBEE RISHEL 2. Date of Death Month Month Month March 30, 2004 3. Time of Death March 30, 2004 3. 3. Time of Death March 30, 2004 3. 3. Time of Death March 30, 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CARROLL
	Funeral Director		5. Social Security Number 6. Sex 219-40-7907 1 M 2 F 65 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 1 County 10c. City, Town or Location 1 Induction Induct
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Medical Exerting Incoming the notified at once.	ai Director	MD. CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 CHARLES ST., APT. E 21157 USA
9003	hours after deat urel', or Items ?	d by Funeral	11. Marital Status 1
Maryland 21215-0036	filed within 72 t Hygiene. other than "nati ent, the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+) HOUSEWIFE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retiried) HOME MAKER 18. Mother's Name (First, Middle, Maiden Surname)
Marylan	d 2 should be th and Mental ?7 Is marked o treumatic eve	To Be	JAMES FINCHAM EMILY WINDER City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES R. RISHEL – SON 41½ LIBERTY ST., WESTMINSTER, MD. 21157
Baltimore,	it. Pages 1 and inment of Health intant: If item 27 njury or other to		20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 1 M Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 M Donation 5 Other (Specify) MEADOWRIDGE MEM.PARK 4/2/04 ELKRIDGE, MD.
Ba	permit. Departi Importe eny inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Approximate Interval Between Onset and Death
8760,	Cate be executed /Medical Examiner buysician and the burial-transit	dicai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cis as or in any that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
P.O. Box 6	requires that the death certifics een signed by the attending pt hould be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
	w requires that s been signed b s should be deta	Completed by Pf	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MORBID OBESITY 23e. Did tobacco use contribute to the cause of death? 1
Vital Re	Physician: The law this certificate has b ral director, page 2 si	Be	autopsy performed? death? 1 □ Yes 2▼ No 25. Was case referred to medical examiner? Hospital:
Division of Vital Records,	ding Ph h. After th funeral	Certification; To	27. Manner of Death 1
Div	Hospitet or 4 hours afte Funerel Dir ely filled in	edical Certif	29a. Certifier (Check only (Ch
	Within 5 comple	_	29c. License number D0051926 29d. Date signed (Month, Day, Year) APRIL 2, 2004
	Sta Registra		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HERBERT HENDERSON MD 2973 MANCHESTER RD., MANCHESTER, MD. 21102 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 0 2 2004

			For State Registrar	State of Maryland / De	epartment of He Certificate of D		lental Hygien	Z1111b	12394
			1. Decedent's Neme (First, Middle, Las	(1)			2. Date of Death	V	3. Time of Death
	Physici		Eunice	Robertson			Month Da March 2	3 2004	11:16 a ^M
	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)	4b. City, Town, or L	ocation of Death	44	c. County of Deeth	
ı			Holy Cross Hospita	1	Silver Sp	ring	Мо	ntgomery	
	Funeral		5. Social Security Number 6. S		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year	9. Birth	place (State or Foreign ntry)
5.	Director		434-20-2778	□M 25□F 81 Yr	s. Months Bays	110410	Jan. 13,	1923 New C	ríeans,Louisar
	Pu .		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location		-		10d. Inside City Limits
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Exeminer manks nutilised at	٦	Maryland Montgomer						1⊠Yes 2 □ No
	Ba-f	Director		.y DIIVEL L			10-0	**	
	with t	급	10e. Street and Number	0	10f. Zip Code			itizen of What Cou	
	s 23	Funeral	9101 2nd Ave. Silv		20901	O-i		14. Race - Ameri	s America
	er de Item	nu	11. Marital Status		 Was Decedent of Hisp If Yes, specify Cuban, 	, Mexican, Puerto	Rican, etc.)	Black, White,	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ② Widowed 4 ☐ Divorced	1 Tyes 2 XNo If Yes, Give Year or Dates:	1 ☐ Yes 2 🖾 No	Specify:		Specify: B1	ack
Maryland 21215-0036	hou tura		15. Decedent's Ed		ecedent's Usual Occupati	ion	16b. l	Kind of Business/Ir	dustry
5	in 72	Completed	(Specify only highest gra	de completed) (0	Give kind of work done du ife. DO NOT use retired)		ing		,
2	with ene. thar	E C	Elementary/Secondary (0-12) 12	College (1-4or 5+)	k		Fe	deral Go	vernment
2	Hygi Hygi ther		17. Father's Name (First, Middle, Last)		1	18. Mother's Name	e (First, Middle, Maide	n Sumame)	
an	d be ental	o Be	Daniel Morris			Maud The	riot		
2	Shoul mark	-	19a. Informant's Name/Relationship	Type, Print) 19b. N	Mailing Address (Street an			or Town, State, Zij	Code)
<u>S</u>	ich ar Ith ar 27 is 17 is		Winston O. Roberts	son, Jr./Son 108	302 Black Po	wder Ct.	Ft. Wash	ington. 1	Md 20744
ē,	Health tem 27 l		20a. Method of Disposition	20b. Place of D	isposition (Name of			ocation - City or T	
more,	Pages nent of int: If it		1 🗓 Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify	Hemoval from State	crematory or other place)	1	/2004 Bro	ntroad 1	Lantand
=		- 33	21. Signature of Funer I Service Licen		ncoln Cemet			ntwood, l	aryrand
Ba	Departr Departr Imports any inj once.) homes	3 10/1/1	Fort Lincol 3401 Bladen			od Maryl	and 20722
			23a Part1 Enter the disease or com	plications that caused the death. Do no				ou Haryre	Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Cardio Pulmonar					1 Hour
	Examiner			Due to (or as a consequence of)		. 51			0.0 ***
		70	Sequentially list conditions, if any, leading to immediate	b. Coronary Arteri		Heart Di	sease		20 Years
	be.	Examiner	cause. Enter Underlying Cause (Disease or injury	Generalized Ath		c		İ	20 Voors
_	and and	xan	that initiated events resulting in death) Last	C. Due to (or as a consequence of)					30 Years
8760,	The law requires that the death certificate be executed the has been signed by the attending physicien and cage 2 should be detached for use as the burran situans it.	aiE							
	phys the	dicai	•	d					
9 X	death certifica attending plant for use as t	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregnancy				22d Date of deliv	
Box	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deliv Month	Day Year
P.O.	the de	ysic	1 ☐ Yes 2 🙀 No 9 ☐ Unknown	9 Unknown	3 Other (specify)				
٥.	es that the death cer igned by the attendir be detached for use			ontributing to death but not resulting in t	he underlying cause given	in Part I.	23e. Did tobacco	use contribute to t	he cause of death?
Division of Vital Records,	signe d be	Completed by	_	ion with left Hemi	, , , .		1 ☐ Yes 2	2 XNo 3 □ Proi	oably 4 DUnknown
0	w require been signal	etec							
ec	a law has t	npi					24a. Was an autopsy	prior to co	opsy findings available impletion of cause of
=		Ç					performed? 1 ☐ Yes 2 ☑ N	death? o 1 ☐ Yes	2 No
/ita	Attending Physicien: The la r death. ector: Atter this certificate has by the funeral director, page 2	Be	25. Was case referred to medical examiner?				h (Check only one)		
1	hysi his c	မ	1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp		4 [] Nuising no	me 5 Residence		(y)
2	ng P fter t	:uo	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer) 28b. Tin	ıry Work?		28d. Describe how inju	ury occurred	
<u>sio</u>	or Attending after death. Director: After in by the funer	Certification:	2 Accident investigation			es 2 No			
Ξ̈́	after d Direct in by I	ţ	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office		28f. Location (Street a City or Town, Stat		al Route Number.
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral					1			
	Hospital 24 hours a Funeral stely filled	edical	29a. Certifier 1 ← Certifying Ph (Check only 2 ← Medical Exam	ysician: To the best of my knowledge, on the basis of examination and/	death occurred at the time or investigation, in my opin	, date and place, nion, death occur	and due to the cause(s	s) and manner as s	tated. o the cause(s)
	To the Howithin 24 To the Fu	led	one)	and manner stated.					
	To To COLT	Σ	29b. Signature and title of certifier	0 1.	29c. License i			ate signed (Month,	
,	F		Zlev augh	letter	D0004	4814	[11)	Arch 24,	0007
)	(3)	1		completed cause of death (Item 23a) (Tr					
				on, M.D. 1629 Colu	mbia Rd N.W.	. Suite	334, Washir	ngton, D.	C. 20009
	Sta	ite	31. Date filed (Month, Day, Year) ADD 0 9 200	7. Registrar's Signature	1				

Maryland 21215-0036 abinson,

> P.O. Box 68760 Division of Vital Records.

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) March **Physician** 0005 M Senie Mae Robinson 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Specially Hospital INIVERSIT Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 217-22-4156 87 1 □ M 2 🖳 F Director North Carolina April 15, 1916 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 27 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Examinat must be notified at Baltimore Maryland 1 √yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4800 Seton Drive 21215 U.S.A. e filed within 72 hours after death val Hygiene.
other than "natural", or Items 23s 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 12 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker Hospital permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other treumant: 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Obie Robinson Lessie Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Johnetta Humphrey 2704 OCOLY Terrace Baltimore MD 20b. Place of Disposition (Name of cemetery, crematory or other p 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State St. Lauis Baptist Church Marche Park har lotte Court House, Va. ^ 4 □Donation 5 □ Other (Specify) Address of Facility 21. Signature of Funeral Service Licensee Dum & Sons Funeral Services 5635 Eads Street, N.E. Washington, D.C. 20019 Denti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final ebsis Physician day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner courte unnary 3 do Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit fensor Du t (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 □Unknown 1 ☐ Yes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2X No 1 ☐ Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ampatient Certification: To 1 ☐ Yes 2 Z No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Medical 29a. Certifier 1🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number CPMelita NO D34974 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601, charles Street, Baltimore, MD 21230 puD. CHARUMEHTA . Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 3 0 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 12396 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ream 18/2004 Alfred 2:10 A M Stephen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville <u>Shady Grove Adventist Hospital</u> If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 03/17/2004 Birthplace (State or Foreign Country) **Funeral** Days Months <u>₩</u>M 2□ F Hours Vrs Director Marvland NONE Usual Residence of Decedent 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 2X No Maryland Montgomery Gaithersburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20878 977 Clopper Road death v Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after di Il Hygiene. other than "naturel", or Item 1 ☐ Yes 2 ₹ No If Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Importent: If item 27 is marked other the any injury or other traumatic event, Iffair Once. N/A N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stacy Lynn Robey Stephen Edward Ream 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacey Lynn Ream / Mother 977 Clopper Road T-2 Gaithersburg, MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 03/29/2004 Clinton, Maryland Resurrection Cem. ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address Officially P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745 21. Signature Funeral Service Licensee 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final txtreme Inon aturity Physician 4 hrs 40 anin disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed behalf Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by i ciency des Wess Respiratory 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 1 ☐ Yes 2X Mo 1 Tes 2□ No Division of Vital To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No After th 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide 1 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Vietela 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 43225 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville Medical Center De NIGAM Ma MADHU 9901 31. Date filed (Month, Day, Year) B2. Registrar's Signature MAR 3 0 2004 Registrar

Physicia	an	1. Decedent's Name (First, Middle, L Maria Gabriela	,	20.5			2. Date of D	Day	Year	Time of Death
/Medic Examin		4a. Facility Name (If not institution, g		105	4b. City, Town, o	r Logation of Do	March			22P
=xamin	er	Frederick Memori	·		Frederic		ain		ty of Death	
uneral			Sex 7. Age (In)	yrs. last birthday) If Under 1 Year	If Under 24 H	Irs. 8. Date of Bi	rth	erick 9. Birthplace	State or Fore
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*		Usual Residence of Decedent 10a. State 10b. County	10c.	. City, Town or L	ocation				104 In	oido Cita Lin
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Vent	Be C	17. Father's Name (First, Middle, Las	st)			18. Mother's N	lame (First, Middle	, Maiden Suma	me)	
etic e	To Be		AMADO MERINO			Cruz	Crespin			
reumetic event, I'm Ms		19a. Informant's Name/Relationship Angelica Noemy	(Type, Print)	19b. Mail	ing Address (Street a)
ther		20a. Method of Disposition			8 Apple W.	ay F	rederick			
any injury or of		1 🕅 Burial 2 □ Cremation 3 [☐Removal from State	cemetery, cre	matory or other plac	04-	Date 02-04		• City or Town, Si	
injur,	ř	* 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Fungral Service Lice	The state of the s	-	Cemetery					
any ir		Manda CV	Bonon MA	3/0/3	2. Name and Addres	St. N.W	 H. Bacc Washir 	on Funer	cal Home, DC 20010	, Inc.
		23a Barti Enter the disease or con	square, cur	961		~ ~ ~ , , , , , , , , , , , ,	· nasiiii	IE COII 9 I	JO ZUUIU	
		20a. Fait i. Enter the disease, or con	nplications that caused the d	eath. Do not en		g, such as cardi				oximate
ician		23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final	mplications that caused the d y one cause on each line.	eath. Do not en	ter the mode of dying		ac or respiratory a	rrest,	Appro	oximate ral Between it and Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 30, 5:00 2004 Louise E. Roberts March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Sandy Spring
If Under 1 Year If Under 24 Hrs. Montgomery Brooke Grove Nursing Home Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 🖾 F 1912 16, 92 Washington, DC 579-50-6959 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State in then "natural", or Items 23e or 28e-f show the Medical Examinational be notified at 1 ☐ Yes 2 12 No Directo Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 USA 15311 Pine Orchard Drive, 3E death v Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event pies. Be Lewis Warner Crosby Laura Elizabeth Warfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16916 Old Colony Way, Rockville, MD 20853 Neil E. Roberts/ Son 20b. Place of Disposition (Name of cometery, crematory or other place)
Gate of Heaven
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition April 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) 2004 Silver Spring, MD 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 nchen ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final 2 Weeks Physician Myocardial Infarction resulting in death) /Medical Due to (or as a consequence of): **Examiner** Coronary Artery Disease Many Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 1 Tes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 Inpatient Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To After the 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No Diractor: / 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D43202 March 31, 2004 30. Name and address of person who completed cause of dean (Item 23a) (Type, Print) 3305 North Leisure World Blvd., Silver Spring, MD 20906 C. Ozanne-Blankford M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State sacks/ APR 01 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Manor Care- Silver Spring
7. Age (In yrs. last birthday) Montgomery 8. Date of Birth (Month, Day, Year) Feb. 11, 1 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 🖾 F Yrs **1911** 93 Cuba Director 226-58-3712 Usuat Residence of Decedent the Manyland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or itams 23a or 28a-f show event, the Modical Exacting must be notified at 1 ☐ Yes 2 No Directo Maryland Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20904 400 Warrenton Drive USA death v Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after ☐Yes 2 ☑ No Yes, Give 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☑ Yes 2 ☐ No Specity: Cuban Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 Housekeeper Homemaker 18 Mother's Name /First Middle Maiden Sumame 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any linjuy or other traumatic event once. Be Unknown Unknown ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mathilde B. Lee/ Friend 400 Warrenton Drive, Silver Spring, MD 20904 20b. Place of Disposition (Name of cometery, crematory or other place)
Gate of Heaven April 2. 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD Cemetery 21. Signature of Funerat Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END S CONGESTIVE HEART FAILURE TAGE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy 1 Live birth in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No be detached 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ٩ 1 Tes this 27. Manner of Teath 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Medical Certification; After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. M after death the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a To the Funeral C 0

29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifier MD D5679 March ladikonda, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENU BALTIMORE 3952

Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2004

State Registrar 31. Date filed (Month, Day, Year)

29a. Certifier (Check only one)

32. Registrar's Signature

and manner stated.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) March Physician RODRIGUEZ 26^y, 2004 11:20 PM ROMELIA AGUILAR /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Jan. 29, 1979 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Mexico 25 None Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show the Medical Examiner must be notified at Md. Montgomery Gaithersburg 1 XYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 38 Brian Court 20877 Mexico death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes. Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Mexican 1X Yes 2□ No Specify: Mexican þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 4 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be finand Mental H permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked eny injury or other traumatic events. Anselmo Rodriguez Zalas Heriberta Auguilar P. Roblero 19a. Informant's Name/Relationship (Type, Print) (Brother) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reinaldo Rodriguez Aguilar 38 Brian Court Gaithersburg, Md. 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State April 7, * 4 ☐ Donation 5 ☐ Other (Specify) Acacoyagua, Cemetery Chiapas, Mexico 2004 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877 well 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Tutra cranial

Due to (or as a consequence of) **Physician** Hemorrhage 24 hours /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner this certificate has been signed by the attending physicien and al director, page 2 should be detached for use as the burial-trai resulting in death) Last Due to (or as a consequence of) O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 ☐ Yes 2 🖟 No myelogenous levkemia 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? Thrombocytopenia autopsy performed 2 🗆 No 2 **X** No 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Medical Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After : 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Hospital 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) March 27, 10060117 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric J. Park, 100 9901 Medral Center Drive, Rockville, MD 20650 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 01 Registrar

Romalia Rodriguez

			1 - For State Registrar	State of Maryla	and / Dep <i>Ce</i>	artment rtificate	t of H	ealth ai Death			Reg. No.	20	04	. 010	401
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3	hours after lural', or ita	by	3 X Widowed 4 ☐ Divorced	If Yes, Gi Year or D	ve Dates: WWI	I	1□Yes 2ሺNo	Specify:		Specify	WHI	TE
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Division of Vital Records,	P in it e	Certification:	3 Suicide 6 Could r 4 Homicide determ	200. Flat	e of Injury - At I ling, etc. (Spec	nome, farm, st ify)	reet, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	ər or Rura	al Route Number,
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	V	iii	30. Name and address of person		se of death (Ite		Print) 866	1.2 Ad	Ave Sil	ver spr	7g. N	ND 20910
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth March 18 2004 ar Physician Pearl Natalie Repp 7:20pm /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Julia Manor Health Care Hagerstown, Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Sept. 16, 1911 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** Country)
MD 1□ M 21XF 92 Director 215-20-8231 Usuel Residence of Decedent permit. Pegas 1 end 2 should be filed within 72 hours after death with the Marylend Depertment of Health end Martel Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evandret must be notified at 10c. City, Town or Location 10a, Stete 10b. County 10d. Inside City Limits MD Washington Clear Spring, 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 13522 Blairsvalley Rd. 21722 U.S.A. Be Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, et 1 Never Married 2 Married 1 ☐ Yes 2 XNo white Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: If Yes Give Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) private homes Elementary/Secondary (0-12) College (1-4or 5+) domestic worker 0 8th grade 18. Mother's Name (First, Middle, Maiden Surname)
Mary Trumpower 17. Father's Neme (First, Middle, Last) Russell Seibert 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
14727 St. Paul Rd. Clear Spring, MD 21722 19a. Informant's Name/Relationship (Type, Print) Donald Repp 20b. Place of Disposition (Name of cametery, crematory or other place) Mar. 22, 2004 20c. Location - City or Town, State Blairsvalley Cemetery Clear Spring 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Clear Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc P.O.BOX 310 Clear Spring, MD 21722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw nset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) ENSIVE CARDINASCULAR DISEASE Examiner Examiner eate has been signed by the attending physician and page 2 should be detached for use es the burial-transit or Attending Physician: The law requires thet the death certificeta be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of) Physician/Medical Due to (or as a consequence of) Part II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No à 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes en autopsy performed? certificate 1 LI YES 2 DANG 1 ☐ Yes 2 ☐ No versi Director: After this certific filled in by tha funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medical 29a. Certifier f **Certifying Physicien**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

Division of Vital Records, P.O. Box 68760. within 24 hours after death.

To the Funeral Director: All completaly filled in by tha fu Hospitai the P 18 State

31. Dete filed (Month, Day, Year) MAR 23 2004

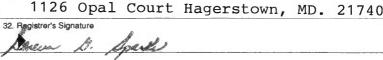
222 60

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

Waseem

29b. Signeture end title of certifier

Khalid M.



Registrar

29c. License number

052323

29d. Date signed (Month, Day, Yeer)

		•	For State Registrar	State of Mary		artment of H		Reg	ene 200	1 10 7
>	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Las Roger Eugene Reed 4a. Facility Name (If not institution, give	street and number)		,	r Location of Death	2. Date of Death Month Manch	Day Year 14 200 4c. County of Dee	th
	Funeral Director		219-20-6209		n yrs. last birthday) 73 Yrs.	Hagerst If Under 1 Year Months Days		8. Date of Birth (Month, Day, April 12	Washingt Year) 9. Bir O,1930 Ma	on thplace (State or Foreign puntry) ry land
	72 hours after death with the Maryland natural; or Items 23e or 28e-1 show dical Examinatin ust be rediffed at		Usual Residence of Decedent 10a. State 10b. County Maryland Washing 10e. Street and Number		Boonsbore			10	g. Citizen of What C	10d. Inside City Limits 1 X Yes 2 ☐ No
	eath with the same or 2		31 Schoolhouse Col	urt	rin U.S. 13.1		21713		USA	
9036	thin 72 hours after death with the Marylan 8. ** "natural", or Items 23a or 28a-1 show Wedical Examinatinust be rediffed at	by Fur	1 Never Married 2 Married 3 Widowed 4 X Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Ko	orea	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🂢 No	Specify:		Black, Whi	te, etc. n i †e
Maryland 21215-0036	d within jiene. r than "	Completed	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired inist	during most of world	king	6b. Kind of Business efrigerat	ion Manuf.
yland	d be ental ked c	To Be C	17. Father's Name (First, Middle, Last) George Columbus	Reed			Frances		Whitmore	
	s 1 and 2 should Health and Milem 27 is mar other traumati		19a. Informant's Name/Relationship (Peggy R. Morgan/ 20a. Method of Disposition	Sister	3812	Chestnut	Grove R	d. Keedy	City or Town, State, SVIIIe, MD Oc. Location - City or	21756
Baltimore,	permit. Peges 1 Department of H Importent: # Ite any injury or ot		20a. Method of Disposition 1 XBurial 2 Cremation 3 Cremation 5 Other (Specification 5 Signature Fundal Service) 21. Signature Fundal Service 22. Signature Fundal Service 23. Signature Fundal Service 24. Signature Fundal Service 25. Signature Fundal Service 26. Signature Fundal Service 27. Signature Fundal Service 28. Signature Fundal Service 29. Signature Fundal Service 29. Signature Fundal Service 20. Signature Fundal Service 20. Signature Fundal Service 20. Signature Fundal Service 21. Signature Fundal Service 22. Signature Fundal Service 23. Signature Fundal Service 24. Signature Fundal Service 25. Signature Fundal Service 26. Signature Fundal Service 27. Signature Fundal Service 28. Signature Fundal Service 29. Signature Fundal Service 29. Signature Fundal Service 29. Signature Fundal Service 20. Signatu	(V)		Cemeter Name and Addre	y 03-17	7-2004 H	agerstown eral Home,	,Ma r yland
760,	Physician /Medical Examiner	ical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underflying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	onsequence of):	er the mode of dyin	ng, such as cardiac	or respiratory arres	st, -	Approximate Interval Between Onset and Death U. Market
.O. Box 68	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of a 1 □ Live birth 2 □ 4 □ Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of de Month	livery Day Year
Δ.	quires that n signed b uld be deta	þ	Part II. Other significant conditions of	contributing to death but n	not resulting in the u	inderlying cause giv	ren in Part I.			o the cause of death? robably 4 Donknown
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ion of Vital	shys this al dir	ToB	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigatio		2 ER/Outpatier 28b. Time o Injury	f 28c. Injur Wor	ler: 4 □ Nursing H		nce 6 □Other (Spe	ecify)
Division	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Specify)			City or Town,		
	To the Hospital or within 24 hours afte To the Funerel Dis completely filled in	Medical	(Check only 2 Medical Example)	nysician: To the best of n miner: On the basis of ex and manner stated	camination and/or in	vestigation, in my o	ppinion, death occu	rred at the time, da	te and place, and du	e to the cause(s)
	Vith V	2	29b. Signature and title of certifier	- MO		29c. Licens	4728		d. Date signed (Mon	
r	Xxx		30. Name and a rivess of person who	completed cause of deat	th (Item 23a) (Type,	Print) Le Hill	Ane 1	tra m	6 217	41
	Sta Regist		31. Date filed (Month, Pay Year) ng	2004 32. Registrar's	Signature	perke.		1	·	

			For State Registrar	State of Mary	land / Depa	artmer rtificat	nt of H te of L	ealth and Death	Mer		iene 2	004	12	405
			Decedent's Name (First, Middle, Last	1)					2.	Date of Deat	h		3. Time of	Death
	Physici		Martha Marie	Rider					Α	Month pril	Day	2004	11:00	ОАМ
>	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or	Location of Deat			4c. Count	y of Death		-
	LXdiiii		18626 Donald St	reet			Hage	erstown				Washi	naton	
	Funeral		5. Social Security Number 6. Se	7. Age (In	yrs. last birthday)	If Unde Months	r 1 Year	If Under 24 Hrs Hours Min	8.	Date of Birth (Month, Day, ril 24	Yeer)		lece (Stete o	or Foreign
	Director		212-38-7856	□M 2√F	65 Yrs.	Nontria	Days	110013	Ap	ril 24	,1938	Ma	rýlano	<u></u>
	pu 🗼		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Le	ncation						1	0d. Inside Ci	ity Limits
	aho	7			, ,								1 🗆 Yes	
	the N	ect	Maryland Wash	ington		Hage	rs10v	VΠ		11	0g. Citizen of	What Cour	itry?	
	a or	by Funeral Director	A	4		101. 22		1742			og. 01.1.201 07			
	ns 23	era	18626 Donald St	12. Was Decedent Ever	in U.S. 13.	Was Dece		I /4∠ ispanic Origin? (\$ in, Mexican, Puer	Specify	Yes or No-	14. Ra	USA ce - Americ	an Indian,	
"	r Iten	Fun	1 Never Married 2000 Married	Armed Forces? 1 ☐ Yes 2 ☑ No					to Ric	an, etc.)	Bia	ck, White,	etc.	
036	al', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗌 Yes	2 X) No	Specify:			Specia	y:	Whit	ŀе
21215-0036	within 72 hours after death with the Maryland one than "natural", or Items 23a or 28a-f ahow na Medical Exament must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dece	dent's Usu	ual Occupa	ation during most of wo	rkina		16b. Kind of B	lusiness/Ind	dustry	
21	thin 9	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.			during most of wo	3					
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pu	iould be filed withing Mental Hygiene. Parked other than natic avent, IDE M	Be	17. Father's Name (First, Middle, Last)					18. Mother's Na	•					
yla	i Men marke	To	Ernest F. M	ills	105 14:11		- /Caa	Sallie and Number or R			Cloppe		Cadal	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic avent, the Medical Examination and the notified at once.		Bobbie L. Rider					Street			own,Ma			1/12
	1 and 2 Health tarm 27		20a. Method of Disposition		0b. Place of Disponentery, cre				Date		20c. Location			72
nor	Pages nent of int: If it		1XXBurial 2 ☐ Cremation 3 ☐	Hemovai from State				I I		2004	Willia		+ Ma-	امما
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4	Physician	ļ.	Immediate Cause (Final	one cause on each line.	1-2:21		0	1 2000	1			,	Onset and	
	/Medical		disease or condition resulting in death)	a. Due to (or as a co	insequence of):		1	NIICK	1				140	
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	Due to (or as a co	nsequence of):									
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٥	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit		Part II. Other significant conditions co	ontributing to death but no	ot resulting in the	underlying	cause give	en in Part I.		23e. Did tob	acco use con	tribute to th	e cause of o	death?
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Vital		Be C	25. Was case referred to medical					26. Place of De	ath (C			10103	20110	
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0	ding Ph h. After th funeral		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of	of	28c. Injun Worl	y at k?	28d	. Describe ho	w injury occu	rred		
<u>S</u>	ending sath. or: After he fune	atic	2 Accident investigation			М		Yes 2 □No						
Division of	r Att ter de irect	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, si Specify)	reet, facto	ry, office		281.	Location (St. City or Town	reet and Num. ı, State)	ber or Rura	I Route Num	iber,
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	To the Hospital or Attendity within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier Certifying Ph (Check only 2 Medicel Exemone)	ysician: To the best of m niner: On the basis of exa and manner stated	amination and/or in	th occurred rvestigation	a at the tim n, in my o	ne, date and plac pinion, death occ	e, and urred	at the time, da	ause(s) and mate and place,	anner as st and due to	ated. the cause(s	i)
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	F 3 F 8)	112	17	1	14/11	M	2	4/1.	101	Ĺ	
	U		130. Name and address of person who	completed cause of death	(Item 23a) (Type	, Print)		1764			1/4/	111		
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		ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	locale .			,			M	180	1741
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Registrar

State of Maryland / Department of Health and Mental Hygiene 12406 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** FAYE MITCHELL SMITH March 25, 2004 0638 A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 704 Market Street Pocomoke City

If Under 1 Year | If Under 24 Hrs. |
Months | Days | Hours | Min. Worcester 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 20 F Yrs. 214-32-6083 68 Director 1/13/1936 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28e-f show the Medical Examiner must be notified at 1 Yes 2 No MD Director Worcester Pocomoke City 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? or Items 23a or 704 Market Street 21851 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ۵ 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ring most of working Il Hygiene. other than " Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Domestic Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Imporhent: If tiem 27 is marked other any injury or other traumatic event 2008. Be Walter P. Mitchell Elizabeth Ellen Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Freddy Mitchell 2107 Orchard Drive, Pocomoke City, MD Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Remson Cemetery 3/28/2004 Pocomoke City, MD 22. Name and Address of Facility Holloway Melson Funeral Home 21. Signature of Funeral Service Licensee Mul 103 Linden Ave., Pocomoke, MD 21851 Dean 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician Division of Vital Records, P.O. Box 68760 Physician/Medical the page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☑ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 esidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident completely filled in by the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number of person who completed cause of death (Item 23a) (Type, Print) MAR 2 9 31. Date filed (Month State 2004 Registrar

			1 - State Registrar	State of Maryland	l / Depa		t of H	ealth a		ental Hy	aieneo o	04	12407
	Dhusisi		1. Decedent's Name (First, Middle, La	st)						2. Date of De. Month	ath Day	Year	3. Time of Death
	Physici /Medio		Jane L.	Showar	-ce					3	25	04	215PM
	Examin		4a. Facility Name (If not institution, giv FAIR HAVEN HEALT)			SYK	ESVI)	Location of				of Death	
	Funeral Director		215-12-2239	7. Age (In yrs. Ia	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da MAY 2	3 1921	9. Birthpl Count MAR	ace (State or Foreign rv) YLAND
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	ocation						10	Od. Inside City Limits
	Manyl f sho	ō	MD CARRO	OLL SY	KESVI	LLE							1 Yes 2 □ No
	the 288	ec.	10e. Street and Number			10f. Zip	Code				10g. Citizen of V	/hat Count	iry?
	3a or	<u> </u>	7200 THIRD AVEN	UE .		2	1784	-5201			USA		
	ms 2	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13.	Was Deced	lent of His	spanic Orig	in? (Spe	cify Yes or No Rican, etc.)	14. Race	- America	
9	after or Ite		1 X Never Married 2 ☐ Married	1 ☐ Yes 2 X No				Specify:	, Puerto r	rican, etc.)		k, White, e	HITE
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and	be fi	Be										θ)	
Ž	should nd Men marke umatic	ို	CHARLES G. SHO 19a. Informant's Name/Relationship (10h Mailie	a Addross	(Street a			CHOWECE	er, City or Town,	Ctata Zia	Code
Maryland	d 2 st th and 7 is r treur			• • • • • • • • • • • • • • • • • • • •		-					LE, MD 2		C00e)
	1 and Health em 27 ther tr		LELIA B. WRIGHT/ 20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Nan	ne of			ate	20c. Location -		vn. State
و	ages intof		1 ☐ Burial 2 🙀 Cremation 3 ☐	CO.	APEAK NTER,	matory or of	ther place	ON .		0 2004			
Baltimore,	it. P.		' 4 □ Donation 5 □ Other (Special 21. Signature/of Funeral Service Lices								STEVENS		
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other treumatic event, the Madical Examinar must be notified at once.		Thomas K.	Hellenhem	40	8 S.	LIBE	RTY S	т.,	CENTRE	M FUNERA	L HON D 216	Œ, P.A. 517
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conseque	enca of):	K)-em	en b.	· N.				Interval Between Onset and Death
68760,	ficate be executed physician and s the burial-transit	ical	resulting in death) Last	Due to (or as a conseque	ence of):								
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetel of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3□	∃Ectopic pre ∃ Other (spe					23d. Date Mor	e of deliver oth	y Day Year
	w requires that been signed by should be deta	by	Part II. Other significant conditions of	contributing to death but not result	ting in the u	nderlying ca	ause give	n in Part I.			obacco use contr es 2 No		e cause of death?
Records,	sicien: The law requ certificate has been irector, page 2 shoule	Completed									sy p	Vere autoprior to come eath?	sy findings available pletion of cause of
Vital	ien: artifica ctor,	Be (25. Was case referred to medical exeminer?						of Death	(Check only o	ne)		
of V	Physicien: r this certifica ral director, I	2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	nt 3□ DO	A Othe	r. 4 Nur	sing Hom	ne 5 □ Resid	lence 6 □Othe	r (Specify)	
ion o	ng fe		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	28b. Time of Injury	M 2	8c. Injury Work 1 🗆 Y	at ? ′es 2 □ N		8d. Describe h	low injury occurre	ed	
Division		Medical Certification;	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory	, office		2	8f. Location (S City or Tow	itreet and Numbern, State)	r or Rural	Route Number,
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	edical	(Check only 2 Madicel Exar	nysician: To the best of my know miner: On the basis of examination and manner stated.	on and/or in	vestigation,	in my op	inion, deatl	h occurre	d at the time, of	date and place, a	nd due to t	he cause(s)
)	To the To the comp	Σ	29b. Signature and title of certifier 25	M, wo		29c	License 3	number	ع		3/25/	(Month, D	ay, Year)
			29b. Signature and title of certifier 30. Name and address of person who 31. Date filed (Month, Day 144)	completed cause of death (Item)	23a) (Type,	Print)	.e ~ d	∠. _€	D.	Re	is Less	Lu	n, pdf 2431
	Sta Registi	ite ar	31. Date filed (Month, Day	6 2 32. Registras Signatu	Jr.	Spa	de						

permit. Pages 1 and 2 should be filed within bepartment of Health end Mental Hygiene. Important: if flem 27 la marked other than "ne any injury or other traumatic event once." **Physician** /Medical Examiner bunal-transit Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

Director

Funeral

þ

Be Completed

Funeral

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

Physician/Medical Examiner <u>Ş</u> Completed Be Certification: To

25. Was case referred to medical 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident

28e. Dete of Injury (Month, Dey Year) 5 Pending investigation 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only one)

3 Suicide

4 - Homicide

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier

31. Dete filed (Month, Day, Year)

H0057821

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

2540 Centreville Rd, Centreville MD 21617 Valence GOODNEAN

State Registrar



ORIGINAL

DHMH 16 Rev 6/95

iours efter death. death.

Hospital within 24 hours

To the Funeral Completely filled

the state

		4	For State Registrar		State of	f Marylan		artment of H			giene 2 leg. No.	004	12	409
		3	Decedent's Name (Firs	t, Middle, L	ast)					2. Date of Dea Month	th Dav	Yeer	3. Time of	Death
	Physici /Medic		Ruth	E	sther			Svec		Mar.	31.	2004	5:58	n ^M
1	Examin	_	4a. Facility Name (If not in	nstitution, g	ive street and nur	nber)		4b. City, Town, or	Location of Death	1	4c. Count	ty of Death		E.
1/2			Jones Acr	es As:	sisted L	iving			Arnold			ne Arı		
	Funeral		5. Social Security Numbe		Sex 1 M 2 Q F	7. Age (In yrs. 93	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)	9. Birthp	lace (State o	ir Foreign
4	Director	Šć.	212-22-9457 Usuel Residence of Dece		- X	93	113.			Feb. 8,	1911		MD	
	and and	1		County		10c. Cit	y, Town or Lo	cation				1	0d. Inside C	ity Limits
	Mary f aho	ō	MD	Anne	Arundel			Arn	old				1 🗌 Yes	2 № No
	28a	rec	10e. Street and Number					10f. Zip Code			10g. Citizen of	What Coun	try?	
	within 72 hours after death with the Maryland ene. than "natural", or Itame 23a or 28a-f ahow ha Medical Examinar must be notitied at	by Funeral Director	1349 Jone	s Sta	tion Roa	ıd		2	1012			USA		
	me 2	Jera	11. Marital Status		12. Was Dece	edent Ever in U	.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-	14. Ra	ce - Americ ack, White,		
9	after or Ita	Ē	1 Never Married 2	2 ☐ Married		2 No		1 □ Yes 2 ☑ No	Specify:	o riiodii, etc.)	Spec	_	ite	
03	ral',	d b	3 Widowed 4 □ [ivorced	Year or D	ates:								
5-0036	72 h 'natu	Completed		ecedent's ly highest o	Education trade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor	king	16b. Kind of I	Business/Ind	dustry	
2121	ne ne ne ne ne ne ne ne ne ne ne ne ne n	пр	Elementary/Secondary	(0-12)	College (1	I-4or 5+)		nemaker/S				Hom	0	
S	iled v dygie thert nt. In		12. Father's Name (First,	Middle La	st)		1101	icitatici / Di		ne (First, Middle,	Maiden Suma			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
and	ntal hed of	Be c	Edward Mof		,				Anna He	enniger				
Maryland	12 should be filed within " n and Mental Hygiene. I's marked other than " reumatic event, tha Med	မှ	19a. Informant's Name/F	Relationship	(Type, Print)		19b. Mailii	ng Address (Street			r, City or Tow	n, State, Zip	Code)	
Ma	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene the Health and Mental Hygiene teural is a marked other than "natural", or Itame 23a or 28a-f show then treumatic event, I'm Medical Examination and the notified at		Paul Reeve				818	Stonehur	st Court.	. Annapo	lis MT	21/0	1	
ē,	tem 27		20a. Method of Disposition			20b. I	Place of Dispo	sition (Name of natory or other place		Date	20c. Location			
OL	ages ant of nt: If I		1X Burial 2 ☐ Cre 14 ☐ Donation 5 ☐			State	-	en Cemete	Ann	3001	Glen	Burni	e, MD	
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr. <u>ence</u> .		21. Signature of Fureral			10		Name and Addre		2.A. Seve	erna Pa	rk Fu	neral	Home
Ö	Dep Imp		Come	56	7/20	Sync	2	195 GOV.	Ritchie F	iwy, Seve	erna Pa	rk, M	D 211	46
	Physician /Medical		23a Part 1. Enter the dis shock or heart fail mmediate Cause (Final disease or condition resulting in death)		_ a	caused the dealerch line.	renn	er the mode of dyin	ng, such as cardiad	or respiratory an	rest,		Approxima Interval Be Onset and	tween
	Examiner		Coguantially list condition	00	b/	1014	6						3 4C	47
	₽ #	ner	Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or injury)	ate 2	Due to	(or as a consec	quence of):						1	
	ecute and trans	Examiner	that initiated events resulting in death) Last	1	c. Due to	(or as a consec	mence of):					-		
8760,	be execuician and burial-trar	al E			540 (0	(0. 45 2 55.155)	440.100 017.							
87	phys the	dical			d									
O. Box 6	it the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent preg in the past 12 mor 1 □ Yes 2 ☑No 9 □ Unknown		1 ☐ Live t	tcome of pregn pirth 2 Feta nant at time of o	al death 3	Ectopic pregnancy Other (specify)	/			ate of delive Month		Year
۵	ires that the signed by dibe detac	by Ph	Part II. Other significent	condition	s contributing to d	eath but not re	sulting in the u	nderlying cause giv	en in Part I.		bacco use co			
ord	w requir been si should I	ted								1 D Y	es 2 10 No	3 Prot	ably 4 🗌	Unknown
Division of Vital Records,	The la ate has page 2	Completed										were auto prior to co death? 1 Yes	psy findings mpletion of 240	available ause of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case reterred to examiner?	medical	Hospital:			Ott	000	ath (Check only o		455-16	A leve	my-
of	Phys this ral dii	7	1 Yes 2 No		1 📙		28b. Time o	IL 3 DOA	4 🗆 Nursing r	lome 5 ☐ Resid		ther <i>(Specif</i> urred	y) C	
uo	ding h. After fune	fion	1 Natural 5	Pending investiga		of Injury oth, Day Year)	Injury	Wo	rk? Yes 2 □ No		,,			
isi	Attending r death. ector: After by the funer	fica	O C Odioido	Could no	t be 28e. Place	e of Injury - At h	nome, farm, st	reet, factory, office		28f. Location (S		nber or Rura	I Route Nun	n <i>ber</i> ,
Ö	el or / s after il Dire	Certification;	4 Homicide		build	ing, etc. (Speci	ily)			City or Tou	m, State)			
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director; completely filled in by the	Medical (29a. Certifier 1 (Check only one)	Certifying Medical Ex	ceminer: On the b	e best of my kn pasis of examin order stated.	owledge, deal ation and/or in	h occurred at the til evestigation, in my o	me, date and place opinion, death occu	e, and due to the curred at the time,	cause(s) and r date and place	manner as s e, and due to	tated. the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title	of certifier	1	VI.	1	29c. Licens	se number		29d. Date sign	ned (Month,	Day, Year)	
			Pelli	ac	1_1	UNI	3 my	1120	094		04/6	1/0	7	
سنو			30. Name and address	6	or barry	se of death (Ital	11 6	16 dison	Park	Drul	Con	BURA	11, MO	2106
	St Regist	ate rar	31. Date filed (Month, D	R 0 5		pogistial s sign	K A	ned						

	-	For State Registrar	(epartment of Health and Certificate of Death		g. No.	1241
		Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Deat
Physicia /Medic		James Henry Smit	h		April 4	, 2004	3:20 P
Examin	_	4a. Fecility Name (If not institution, give street	and number)	4b. City, Town, or Location of Deat	th	4c. County of Deat	h
	•	Beverly Health Car	e	Frederick		Frede	rick
Funeral Director		5. Social Security Number 6. Sex 1236-52-0716	7. Age (In yrs. last birtho	Months Days Hours Min		Year) 9. Birt Co 31 Wes	hplace (State or Fore untry) t Virgini
edia este es		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location			10d. Inside City Lin
e-f sho	ctor	Maryland Frederick	Frede	erick			1 Yes 2
a or 28 Lbe no	Dire	10e. Street and Number 30 Northplace		10f. Zip Code 21701		g. Citizen of What Co United Sta	
ns 2:	ега	11 Marital Status 12. V	/as Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Ame	
to Health and Menial Hygiene. If item 27 is marked other than "natural", or items 23s or 28e-f show or other traumatic event, the Medical Exertiner must be routified at	by Funeral Director	1 Never Married 2 Married 1	med Forces? XYes 2 □ No Yes, Give ear or Dates: Korea	If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 No Specify:	to Rican, etc.)	Specify: Wh	
natura lical E	eted	15. Decedent's Educatio (Specify only highest grade cor	n 16a. D	ecedent's Usual Occupation Give kind of work done during most of wo ife. DO NOT use retired)	orking 10	6b. Kind of Business/	Industry
than "	Completed		ollege (1-4or 5+)	ife. DO NOT use retired) Delivery Man		Film Indus	try
Hygie nt. II		17. Father's Name (First, Middle, Last)			me (First, Middle, Ma		*
h and Mental Hygiene. 7 is marked other than " traumatic event, the Mes	To Be	Henry George Smith		Ne11y	Boggs		
h and 7 is m traum		19a. Informant's Name/Relationship (Type, F		Mailing Address (Street and Number or A			Zip Code)
Healt em 2 ther		Andrew Smith / Brot 20a. Method of Disposition		51 Gamber Rd., Fink Disposition (Name of crematory or other place)	Date 2	0c. Location - City or	Town, State
or it of	1	1 ☐ Burial 2 🖾 Cremation 3 ☐ Remo		ciematory or other place)		Frederick	
tmen tant		*4 □Donation 5 □Other (Specify)	riedel	22. Name and Address of Facility S			
Department of Health a Important: If item 27 is any injury or other trau		21. Signature of Funeral Service Licensee	cethis	1621 Opossumtown	Pike Frede	erick, MD	
nysician		23a Part 1. Enter the disease, or complication wheek, or heart failure. List only one call firmediate Cause (Final disease or condition		t enter the mode of dying, such as cardia			Approximate Interval Betwee Onset and Deat Years
/Medical xaminer		resulting in death)	Due to (or as a consequence of		onary bro	Just	1500
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	inbetes Type 1 Suato (or as a nonsequence of	÷			Years
ysician and burial-transit	Examine	mat initiatied events	G.E.R.D				
to an rial-tr		resulting in death) Last	Due to (or as a consequence of);			
physicia the bur	dlcal	d	Hypertension				Years
been signed by the attending physishould be detached for use as the	Completed by Physician/Medi	in the past 12 months?	yes, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of del Month	ivery Day Year
een signed by the	d by Ph	Part II. Other significant conditions contributed Asthma, Anemia, Imm				acco use contribute to	
peen	lete				24a. Was an	24b. Were au	utopsy findings ava
ate has	omo				autopsy perform	ed? death? ∑No 1 ☐ Yes	completion of cause 2XX No
rtific ctor,	Be (25. Was case referred to medical examiner?			ath (Check only one)	
this certific	Jo.	1 ☐ Yes 2 🛣 No Hosp	taf: 1 ☐ fnpatient 2 ☐ ER/Outp	eatient 3 DOA Other: 4 Nursing	Home 5 ☐ Resider	nce 6 Other (Spe	city)
ine in	atlon:	27. Manner of Death 1 ☐ Xatural 5 ☐ Pending 2 ☐ Accident investigation	Ba. Date of Injury (Month, Day Year) 28b. Tir	me of 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how	v injury occurred	
after dea Director	Certification:	a Could not be	Be. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
ours neral filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physicia 2 Madical Examiner:	n: To the best of my knowledge, On the basis of examination and and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occ	ce, and due to the car curred at the time, dat	use(s) and manner as te and place, and due	stated, to the cause(s)
Fur Fur fely	Jec	29b. Signature and title of certifier	7	29c. License number	29	d. Date signed (Mont	h, Day, Year)
ithin 24 h o the Fur	-	(1 1 (1) / /	11 11 11 11 11	1			1
in the nowpited of Average within 24 hours after death. To the Funeral Director: A completely filled in by the fu		Illen Ke	eller M.	D54749	I I	April 5, 2	004
within 24 h		30. Name and address of person who comple Allen Reilly, MD 80	!/			April 5, 2	004

			For State Registrar	State of Maryland		nent of Hea			iene	2004	12411
			Decedent's Name (First, Middle, Last	t)				2. Date of Deat	th		3. Time of Death
	Physici		Joseph	Thadeus	S	chiffer		Month March 2	Day	Year 2004	5:45 PM M
1	/Medic Examir		4a. Facility Name (If not institution, give			City, Town, or Lo	cation of Death	march 2		County of Death	
	aaiiiii		13413 Harrison L	anding Road		Princess	Anne		S	omerset	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last		Under 1 Year If		8. Date of Birth (Month, Day,			place (State or Foreign intry)
	Director		189-14-2846	X(M 2□F 80	Yrs.	inio Days	lours with	01/28/1			nsylvania
	pu .		Usual Residence of Decedent 10a. State 10b. County	10c City To	own or Locatio	n					10d. Inside City Limits
	show ed at	-	Tob. County								1 □Yes 2 XNo
	Ne Ne Ne Ne Ne Ne Ne Ne Ne Ne Ne Ne Ne N	ecto	MD Some	rset Prin	cess A	nne Of, Zip Code			On Citin	en of What Cou	
	with the	늄			"			'	og. Ciliz		and y r
	s 23	ra	13413 Harrison La	nding Road 12. Was Decedent Ever in U.S.	13 Was	21853		city Vac or No-	1.	USA 4. Race - Amer	ican Indian
	ltem ltem	Ě	11. Marital Status 1 ☐ Never Married 2 Married	Armed Forces?	If Yes	Decedent of Hispa s, specify Cuban, I	Mexican, Puerto	Rican, etc.)		Black, White	
36	Ir, or	by F	3 Widowed 4 Divorced	1 MYes 2 □ No If Yes, Give Year or Dates: WWII	101	res 2 No S	Specify:		- 4	Specify:	hite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28e-f show he Madisal Examinar must be notified at	Completed by Funeral Director	15. Decedent's Ed	ucation 10	6a. Decedent's	Usual Occupation	on ,		16b. Kin	d of Business/le	
75	Med n	ple	(Specify only highest gra	de completed) College (1-4or 5+)	life. DO N	of work done duri IOT use retired)	ing most of worki	ng			
5	d with	ШO	12	,	mer/Op	erator			Cab	le Const	truction
	be filed tal Hygie d other event, ii	Bec	17. Father's Name (First, Middle, Last)				3. Mother's Name	(First, Middle, I	Maiden S	Sumame)	
<u>a</u>	Menta	To	Antoine Schiffer				Mary Sie	ebielec			
Maryland	2 sho and !		19a. Informant's Name/Relationship (7	Type, Print) 1	19b. Mailing Ad	idress (Street and	Number or Rura	l Route Number	, City or	Town, State, Zi	p Code)
	and 2 ealth n 27 I		Catherine Schiffe								ne, MD 21853
Baltimore,	- i = =		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐	come	of Disposition etery, cremator	n (Name of ry or other place)	C	ate	20c. Loc	ation - City or T	own, State
Ĕ	Pages nent of ant: If Its ary or o		'4 □Donation 5 □ Other (Specify		wood C	emetery	03/24	4/2004	Prin	icess Ai	nne. MD
alti	permit. Departn Imports any inju	1	21. Signature of Funeral Service Licen	see 🗸	22. Na H i nm	me and Address of an Funer	al Home				
Ω	89 E 29		meson luy	May A. M0029		3 Somers		Prince	ss A	Anne, MI	21853
			23a. Part 1. Enter the disease, or company shock, or heart failure. List only	olications that caused the death. D							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	· antie st.	emas 6	0					Onset and Death Jear(
	/Medical		resulting in death)						-		7
/	Examiner		Sequentially list conditions,	b. Congrativu Due to oras a consequence c. mysta cla Due to oras a consequence	e hed	est face	lune				400-1
	D #	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (b) as a consequence	ce of):	,					1
	cate be executed obysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· mystode	gsp (as	etic s	synde	om			months
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8760,	ate be execul physicien and the buriat-trar	dlcal		d							
39	antifica ing pl	0	IF FEMALE:								
Вох	leath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	ath 3 □Ecto	pic pregnancy			23	3d. Date of deliv Month	ery Day Year
0.	the a	Physician/M	1 Yes 2 No	4☐Pregnant at time of death 9☐Unknown	n 5 □ Oth	er (specify)					,
P.0	d by letach	Ph	Part II. Other significent conditions c	antributing to death but not regulting	on in the under	vina cause diven i	n Parti	23e Did tob	nacco us	e contribute to t	the cause of death?
ls,	requires that the death certific een signed by the attending p hould be detached for use as	Completed by	Part II. Other significent conditions c	Shiributing to death but not resultin	ig in the dilden	yang cause green i	iir aiti.		s 2		1.2
Records,	w require been sig should b	sted									. / \
ec	S CA	ald u						24a. Was a autops	v	prior to co	opsy findings available empletion of cause of
	ate pag	S						perform 1 ☐ Yes 2	neg? Ç⊠No	death?	2□ No
/ita	lysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Lines itali			6. Place of Death	(Check only on	e)		
£	S 5	ို	1 ☐ Yes 2 ☑ No				4 Nursing Hor				fy)
ū	ing P	on:	27. Manner of Death 1. ⊠Natural 5 ☐ Pending	(Month, Day Year)	b. Time of Injury	28c. Injury at Work?		28d. Describe ho	w injury	occurred	
Sic	Attending I ir death. ector: After by the funer	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		A		2 □No	196 Lagation /Ct		Marshau au Oue	- L Douds Number
Division of Vital	or At after of Direction by	Certification:	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	, rarm, street, i	actory, office	'	City or Town	, State)	Number or Hun	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely tilled in by the funeral				d db-		1				
	Hospital Hospital Hours a Funerel I tely filled	Medical		ysician: To the best of my knowled niner: On the basis of examination							
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner stated.		29c. License nu	umber	2	9d. Date	signed (Month,	Dav. Year)
	N N N		Sol digitality and title of contine	11	11						· · · · · · · · · · · · · · · · · · ·
			1/5 rett H		٠,٥	D00599	931		13-25	5-2004	
			30. Name and address of person who		-		noc== ^-	one MD	210	5.2	
			Brett Hoffman, M. 31. Date filed (Month, Day, Year)	D., 30434 Mt. Ve		toad, Pri	incess A	ine, MD	210	7.3	
	Sta Regist		MAP 3	0 2004 Discours	K A	harles					

Amended Item 8 per F.D. 03/30/2004 Carroll County, wil Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day Yeer Z9, 2004 Month **Physician** Stone Eugene 11:00 AM David March /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Center Hospital Carroll Westminster Hours Min. Spanner Brit 1941 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 15 M 2□ F Months Days MARYLAND 215-36-9388 62 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "nature!" --- any Injury or other traumatic executions. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Funeral Director MARYLAND CARROLL WESTMINSTER 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 451 LOGAN DRIVE 21157 UNITED STATES 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status 1 ☐ Yes 2 ☐ No If Yes, GiveXX 1 ☐ Yes ANO Specify: Specify: WHITE Be Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Detes 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) ADJUSTER INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KENNETH MARSHALL STONE LOVA ANN DAVIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) CHERYL L. STONE/WIFE 451 LOGAN DRIVE, WESTMINSTER, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Deurial 2 ☐ Cremation 3 Demoval from State 4 ☐ Donation 5 ☐ Other (Specify) 4/1/04 GLENCOE, PENNSYLVANIA MT. LEBANON CEMETERY 21. Signature of Funeral Service License 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL HOME, P.A. 91 WILLIS STREET, WESTMINSTER, MD 21157 23a. Part1. Enter the disease, or complications that oauled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Pnermonia Examiner Due to (or es a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death cardificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that left and every that left are on the left and the left and the left and the left are of the left and the left are of the left and the left are of the left and the left are of the left and the left are of the left and the left are of the left and the left are of the left and the left are of the left and the left are of the left and the left are of the left and the left are of the left and the left are of the left and the left are of the left are of the left and the left are of the left are and Due to (or as e consequence of). Division of Vital Records, P.O. Box 68760 the attending physician that initiated events resulting in death) Lest Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No evelowal Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 TYes 2 40 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification; To 2 No 1 ☐ Yes 2 ER/Outpatient 3□ DOA 27. Menn of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00059943 March, 29, 2004 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Aroel, M.D. 295 Suite 307 westminster Strer 31. Date filed (Month, Day, Year) MAR 3 0 32. Registrer's Signature State 2004 Registrar A Speck

		State of Maryland / Department of Health and I Certificate of Death		ene Ng 0 0 4	12413
	Physician /Medical	1. Decedent's Neme (First, Middle, Last) Theresz Strohminger	2. Dete of Deeth Month	Day Year 25, 2004	3. Time of Death 5:55 AM
	Examiner	4a Facility Name (If not institution, give street end number) Continuoum Care of Sykesville Syke		4c. County of Death	011
	uneral irector	5. Social Security Number 216-03-4946 6. Sex 93 1 Months Days Hours Min.	(Month, Dey, Y	Yeer) 9. Birthp Cown 1910 Mary1	lace (State or Foreign try)
land	show	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			Od. Inside City Limits
не Мал	Se-fah	MD Carroll Mt. Airy			1 ☐ Yes 21 No
with t	Se or 2	10e. Street and Number 10f. Zip Code 2505 Gillis Road 21771		g. Citizen of What Coun Inited State	
d 21215-0036 filed within 72 hours after daath with the Maryland Hydiene.	et, or items 23a or 28e-1 shor Examiner must be notified at by Funeral Director	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No Specify: 1 Yes 2 No Specify:		14. Race - Americ Black, White, of Specify: Whit	an Indian, etc.
Baltimore, Maryland 21215-0036 emit. Pages 1 and 2 should be filed within 72 hours at beartment of Health and Mantel Hydiene.	ner than "naturel", on the Madical Exam Completed by	15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) 12 15. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Homemaker	king	6b. Kind of Business/Ind	lustry
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larylan 2 should be end Mentel	7 la marke traumatic To	William Salchunas Theresa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	Duback	City or Town, State, Zip	Code)
e, Ma 1 and 2 s	27 r tr	Melvin Strohminger Husband 2505 Gillis Road Mt.	Airy, MD	21771	
TOFE	2 2		March	Oc. Location - City or To	
Baltimo permit. Pag Department	Important: eny injury pnce.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burrier-Queen Fune		lampstead, l tors, P.A.	MD
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/M	sician edical miner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		i_	Interval Between Onset and Death
O, executed	iclen end bunel-transit al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
Box 68760, ath certificate be execut	by the se the edic	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): d.			
D. B.	d by the attanding atached for use of Physiclan/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did toba	acco use contribute to	the cause of death?
P.O.	igned by the a be datached t by Physic		1 🗆 Yes	2 No 3 Prob	ably 4 Unknown
of Vital Records, P.O. Box (Physician: The law requires that the death certif	2 should		24a. Was an a performe	ed? ava	re autopsy findings ilable prior to ipletion of cause eath?
tal H	certificata ha ractor, page Be Com	25. Was case referred to medical 26. Place of Dear	1 Ves		Yes 2□ No
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Division To the Hospital or Attending within 24 hours ettar death.	To the Funeral Director: Attar the completaly filled in by tha funera Medical Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
Hospit 24 hour	Funera etaly fills dicai (29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred end manner end/or investigation.	and due to the caus red at the time, date	se(s) and manner as ste e and place, and due to	eted. the cause(s)
To the	comple Mec	29b. Signature and title of certifier Signature and title of certifier 29c. License number 29c. Doo 59943		Date signed (Month, D	
de	4	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John C. Abel M.B. 295 Sprey Ave. Suite 307 W	185tminste	m Mo	21157
	State Registrar	John C. Apel M.D. 295 Spner Are. Suite 307 W 31. Date filled (Month, Day, Year) MAR 2 6 2004			

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Registrar

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H	Funeral Director			п⊔м аЖбЕ	8		Months	Days	Hours	Min.	Feb 10	y, Year) 192	l Co.	W.Va	
	or 28e-f show	ctor	10a. State 10b. County MD Carro	11	10c. City	y, Town or Lo Westm:		er						10d. Inside City L	
	a or 28 be not	Dire	10e. Street and Number				10f. Z	ip Code	L>				en of What Co	untry?	
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cords, P.	equires man en signed by ould be detai	by	Part II. Other significent conditions	contributing to death b	ut not res	ulting in the ur	nderlying	cause give	n in Part I.			obacco us		the cause of death	
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	Sta Registi		31. Date filed (Month, Day, Year) MAR 3 1	32. Registra 2004	ar's Signa		Some								

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ToB		JOHN D. SWEET	MAN, III			CAROL	J. VAN	DYKE		
To Be Comp		19a. Informant's Name/Relationship	o (Type, Print)	1	9b. Mailing Addre	ss (Street and Number or	Rural Route Num	ber, City o	or Town, Stat	e, Zip Code)
	-	CAROL J. SWEETMA	AN - MOTHER			ER SCHOOL RD				19734
any njury or other trai	2	Oa. Method of Disposition 1 XBurial 2 Cremation 3	□ Removal from State		of Disposition (Natery, crematory or	ame of other place)	Date	20c. Lo	ocation - City	or Town, State
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cal Examiner	t	hat initiated events	с							5 years
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			1 _ For	State of Maryla	ind / Depa		lealth and N	Mental Hyg	iene	ne. 04 12417
	Dhysiai		1. Decedent's Name (First, Middle, L.	ast)		rimeate or i	Jean	2. Date of Dea Month	th	3. Time of Death
	Physici /Media		Helen M.	Stewart				March	24, 20	04 7:15A M
2	Examir	ner	4a. Fecility Name (If not institution, gi			4b. City, Town, or	Location of Death		4c. County o	f Death
			Prince George 5. Social Security Number 6.		s. last birthday)	Cheve If Under 1 Year	erly If Under 24 Hrs.	8. Date of Birth	P.G	
	Funeral Director			1 □ M 2 (\$\frac{1}{2}	59 Yrs.	Months Days	Hours Min.	April	, Year)	9. Birthplace (State or Foreign Country) 44 Wash., DC
	72 hours after death with the Maryland natural', or Items 23a or 28a-f ehow Jical Exandred froughed at		10a. State 10b. County	10c. (City, Town or Lo	ocation				10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, if a Medical Examiner must be notified at ance.	tor	DC		Washi	ngton				1 ☑ Yes 2 ☐ No
	th the	Funeral Director	10e. Street and Number			10f. Zip Code		1	l0g. Citizen of WI	nat Country?
	15 will	al	1806 Benning	Road, N.E.	#A	2000	02		Unit	ed States
	ems erre	Iner	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No-		- American Indian, White, etc.
36	or It	Y.	1 ☐ Never Married 2 ☒ Married	1 ☐ Yes 2 No If Yes, Give		1 ☐ Yes 21X No	Specify:	, , , , , , ,	Specify:	
21215-0036	ural',	d by	3 Widowed 4 Divorced	Year or Dates:						Black
5	nat nat	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of worl	king	16b. Kind of Bus	iness/Industry
7	withir ane. than	E D	Elementary/Secondary (0-12)	College (1-4or 5+)			/		Priv	72 40
D	filed Hyginther ant,		17. Father's Name (First, Middle, Las	t)	ı nc	ousewife	18. Mother's Nam	e (First, Middle,		
au	d be antal	o Be	Royal Ruffin				0	_ **		
Maryland	shoul nd Me mari	2	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street a		a Unkno ral Route Number		tate. Zip Code)
<u>8</u>	nd 2 :		Thomas Stewar	t/hushand					‡A	
อ์	Hea Hea tem othe		20a. Method of Disposition	206.	Place of Dispo	Benning ington, osition (Name of	DC 200	O 2 Date	20c. Locetion - C	tity or Town, State
0H	ages ent of nt: If i		1 ☑Burial 2 ☐ Cremation 3 (14 ☐ Donation 5 ☐ Other (Spec		•	matory or other plac	1	1/2/01	D	07579 1999
altimore,	nit. F artm ortar injui		21. Signature of Funeral Service Lice	insee	/ 2	2. Name and Addres				and, Md. ds F.H.
Ä	Depar Impo		I house s	Edward.			110			as r.H. nd,Md.20746
	Physician /Medical Examiner		23a. Part. Enter the disease, or corsport, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions	a. Respirato Due to (or as a conse Due to (or as a conse Due to (or as a conse	ath. Do not ento ory Farequence of):	ilure Co	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
68760,	ficate be executed g physician and is the burial-transit	edicai Examiner	Secuel fially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse						
P.O. Box	that the death certificate ed by the attending phys detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Monti	
	law requires that the as been signed by th 2 should be detache	y Pł	Part II. Other significant conditions	contributing to death but not re	esulting in the u	inderlying cause give	on in Part I.	23e. Did tot	acco use contrib	ute to the cause of death?
Sp	ures sign	d by	Insulin-Deper	ndent Diabet	es Me	llitus		1 □ Ye	s 2 🗆 No 3	☐ Probably 4 ⊠Unknown
O _O	w requir been s should	Completed	Atril Fibrill					24a. Was a	n 24b We	ere autopsy findings available
Re	0 0	Ę						autops perforr	y pri- ned? de	or to completion of cause of ath?
Vital Records,	ician: Th certificate rector, pag	ပိ	Chronic Renal 25. Was case referred to medical	Failure			OC Place of Deat	1 ☐ Yes 2		Yes 280 No
>	ysician: is certific director.	0	examiner? 1 □ Yes 2 2 No	Hospital:	☐ FB/Outnatier	nt 3 DOA Othe		ome 5 Reside		(Spanify)
ō	를 듣 등	\vdash	27. Manner of Death	28a. Date of Injury	28b. Time o			28d. Describe ho		
lon	nding I th. r: After e funer	atio	1 XNatural 5 Pending 2 Accident investigate	(Month, Day Year)	Injury		r res 2 □ No			
Division	in Dir	Certification:	3 Suicide 6 Could not determined		home, farm, str cify)	reet, factory, office		28f. Location (St. City or Town	reet and Number 1, State)	or Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my ki miner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	h occurred at the tim vestigation, in my op	e, date and place, pinion, death occur	and due to the ca red at the time, da	ause(s) and manr ate and place, an	ner as stated. d due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	2 . A.		29c. License	number	2	9d. Date signed (Month, Day, Year)
	5		I toles	The Mai		D002	6024		March 2	24, 2004
0	(4)		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type,					
_			Dr. Lester Mil	es, M.D., 6	490 La	andover	Rd., Su	ite F,	Landov	er,Md.20785
	Sta Registi		31. Date filed (<i>Month</i> , <i>Day</i> , <i>Year</i>) APR 0 2 2004	32. Registrar's Sign	nature					
	- (2) (1)	e: C	MPH 11 // /11114		- Cont.	# # #				

			For State	State of Maryland /			ental Hygie	ene 2001	10110
			Ragistrar 1. Decedent's Name (First, Middle, La	neti	Certificate of		Reg 2. Date of Death	NOC. UU4	3. Time of Death
	Physic		EMERSON	STEPHENS			Month 03	Day Year	425 DM
	/Medi Examir		4a. Facility Name (If not institution, gir		4b. City, Town,	or Location of Death	05	4c. County of Death	
	LAGIIII		WAHWOOD	ADVINT HUNDA		uma DAR	K	MUNTGO	/szm
	Funeral			Sex 7. Age (In yrs. last bi		If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	9 Birtho	place (State or Foreign
	Director		AAJ- 24-2120	12M 20F 75	Yrs.	Hours Will.	04-0		ginia
	and		Usuat Residence of Decedent 10a, State 10b, County	10c. City, Tow	n or Location	2		1	10d. Inside City Limits
	Maryl feho ieu e	ō	Md. Monto		Koma +	ark			1 ☐ Yes 25 No
	h the Marylan r 28a-f ehow notified at	Director	10e. Street and Number	700	10f. Zip Code		10g	. Citizen of What Cour	ntry?
	death with the Maryland ms 23a or 28a-f show	a la	6416 6	512 Ave.	20	09/2		U.S.F	j ,
		Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of	Hispanic Origin? (Spec oan, Mexican, Puerto F	ify Yes or No-	14. Race - Americ	
98	or tt		1 Never Married 2 Married	1 XYes 2 ☐ No If Yes, Give	1 Yes 2 2/No		ican, etc.)	Black, White,	etc.
Ö	72 hours after naturel', or ite dical Exeruitie	d by	3 Widowed 4 Divorced	Year or Dates:				1 010	acic
21215-0036	in 72	Completed	15. Decedent's E (Specify only highest gr	ade completed)	 Decedent's Usual Occu (Give kind of work done life. DO NDT use retire 	during most of workin	g 16l	b. Kind of Business/Ind	dustry
212	y within jiene. r then	E	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)	Janitoria	r . <	ce L	L.S. Go	Vernment
Þ	be filed wit stal Hygiene of other the	Be C	17. Father's Name (First, Middle, Last) 61 1		18. Mother's Name	(First, Middle, Mai		V //0//
/lar		ToE	Ne wbie	Stephens	>	Bess	pie B	arley	
Maryland	2 sh and is m		19a. Informant's Name/Relationship		. Mailing Address (Stree	and Number or Rural	Route Number, C	ity or Town, State, Zip	Code)
	f Health item 27 other tr		Myra Stept	1en > (bushted 6	416 50 A			ork, nud	20912
O	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	comoto	f Disposition (Name of ry, crematory or other pla	Da	te 200	c. Location - City or To	own, State
Baltimore,	t. Pa tmen tant: njury		` 4 □ Donation 5 □ Other (Speci	1/10///	ony Memoria	180K 4-2	-04 1	andove	amd.
Bal	permit. Pag Department Important: i any injury o		21. Signature of Funeral Service Lice	016	2. Name and Address	ess of Facility 15e	11 Fun	eral Hon	ne P.A.
			23a, Part1, Enter the disease, or com	pplications that caused the death. Do	not enter the mode of dvi	Old Oro	nch H	ve, Tempi	Approximate
	7) Districts		shock, or heart failure. List only tmmediate Cause (Final	one cause on each line.	016	119, 34011 43 5414145 51	rospiratory arrest,		Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consequence	2 Intono	740			
566	Examiner				017.				
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):				
	and I-transi	Examiner	that initiated events	c					
60,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequence	of):				4
98760	ate ohys	dical		d					
9 xc	death certific e attending p id for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregnancy				22d Date of delive	
Box	death atter	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of deliver	ry Day Year
P.O.	t the c by the achec	hysi	1	9□ Unknown					
	n requires that the de been signed by the should be detached	by P	Part II. Other significant conditions	contributing to death but not resulting in	n the underlying cause gr	ven in Part I.	23e. Did tobacc	co use contribute to the	e cause of death?
ırd	aquire en sig ould b	pe					1 🗆 Yes	2 □ No 3 □ Proba	ably Onknown
Records,	2 5 3	piet					24a. Was an autopsy	24b. Were autop	osy findings available
Œ	Tr ate pa	Completed					performed	death?	npletion of cause of 2 ☐ No
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			26. Place of Death (
of	ding Physician: h. After this certific funeral director,	ပ္	1 ☐ Yes 2 ☐ No	Hospital: 1XXInpatient 2 ☐ ER/Ou		4 Nursing Home	5 Residence	6 ☐Other (Specify,)
n C	fing After fune	lon	27. Manner of eath 1 Natural 5 Pending	(Month, Day Year)	Time of 28c. Injury Wo		d. Describe how in	njury occurred	
Division	or Attending after death. Director: Afte in by the fune	icat	2 Accident investigatio 3 Suicide 6 Could not b			Yes 2 □ No	f Loopting (Ctron)	to addition to a second	
Ο̈́	after Direction of	Certification;	4 Homicide determined	28e. Ptace of Injury - At home, fa building, etc. (Specify)	im, street, factory, office	20	City or Town, St	t and Number or Rural (ate)	Houte Number,
	Hospitel 24 hours a Funeral I		29a. Certifier 1 Certifying Pt	nysicien: To the best of my knowledge	, death occurred at the til	me, date and place, an	d due to the cause	a(s) and manner as sta	ated
	To the Hospitel or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Examone)	miner: On the basis of examination and manner stated.	d/or investigation, in my o	ppinion, death occurred	at the time, date	and place, and due to	the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. Licens	se number		Date signed (Month, D	
	(1	- En Idylon	<u></u>	350	127	(23-28-2	004
_	10)	(30. Name and address of person who	completed cause of death (Item 23a) (Type, Print)			n mo	
			2600 Sand A	IE TAXOMA PENK	MI)	MMA D	Wign	J mo	
	Sta Registr		31. Date Titled (Month, Day, Year) MAR 3 1 200	2. Registrar's Signature	boute				
100			MINK O T COO	· ARRENO J A					

Director 064-05-7740 1 M 2 XF 89 Yrs. Months Days Hoteleant 10a. State 10b. County Maryland Montgomery 10c. City, Town or Location Rockville 10b. Street and Number 10c. Street and Number	nder 24 Hrs. B. Date of Birth (Month, Day May 13) 0852 o Origin? (Specify Yes or Noxican, Puerto Rican, etc.)	8, 2004 Year 11:00 P M 4c. County of Death Montgomery 9. Birthplece (Stete or Foreign Country) New York 10d. Inside City Limits 12 Yes 2 No 10g. Citizen of What Country? USA
Medical Examiner 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Local Hebrew Home of Greater Washington Rockvil Rockvil Director 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If	tion of Deeth 1e Inder 24 Hrs. 8. Date of Birth (Month, Day May 13) 0852 c Origin? (Specify Yes or No- xican, Puerto Rican, etc.)	4c. County of Death Montgomery 9. Birthplece (State or Foreign County) New York 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? USA
Hebrew Home of Greater Washington Rockvil 5. Social Security Number 06. Sex 1 Months Days How 2 Months Days How 1 Month	nder 24 Hrs. In the state of Birth (Month, Day May 13) 0852 c Origin? (Specify Yes or Noxican, Puerto Rican, etc.)	9. Birthplece (State or Foreign Country) 1914 New York 10d. Inside City Limits ★ Yes 2 No 10g. Citizen of What Country? USA
Director Usuel Residence of Decedent O64-05-7740 1 M 2 XF 89 Yrs. Months Days Hot	urs Min. (Month, Day May 13) 0852 ic Origin? (Specify Yes or No-xican, Puerto Rican, etc.)	Country) 1914 New York 10d. Inside City Limits 1 Year Yes 2 No 10g. Citizen of What Country? USA
D	0852 c Origin? (Specify Yes or No- xican, Puerto Rican, etc.)	10g. Citizen of What Country? USA
Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code	0852 c Origin? (Specify Yes or No- xican, Puerto Rican, etc.)	10g. Citizen of What Country? USA
106. Street and Number 107. Zip Code	0852 c Origin? (Specify Yes or No- xican, Puerto Rican, etc.)	USA
6121 Montrose Road 2		
The second of th	ecity:	Black, White, etc. Specify: White
The state of Market Market School of Specify only highest grade completed) Shoe Busing the state of Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 17. Father's Name (First, Middle, Last) 18. Mailing Address (Street and Not Specify only highest grade completed) 18. Mailing Address (Street and Not Specify only highest grade completed) 18. Mailing Address (Street and Not Specify only highest grade completed) 18. Mailing Address (Street and Not Specify only highest grade completed) 18. Mailing Address (Street and Not Specify only highest grade completed) 18. Mailing Address (Street and Not Specify only highest grade completed) 18. Mailing Address (Street and Not Specify only highest grade completed) 18. Mailing Address (Street and Not Specify only highest grade completed) 18. Mailing Address (Street and Not Specify only highest grade completed) 18. Mailing Address (Street and Not Specify only highest grade completed) 18. Mailing Address (Street and Not Specify only highest grade completed) 18. Mailing Address (Street and Not Specify only highest grade completed) 18. Mailing Address (Street and Not Specify only highest grade completed) 18. Mailing Address (Street and Not Specify only highest grade completed) 18. Mailing Address (Street and Not Specify only highest grade completed) 18. Mailing Address (Street and Not Specify only highest grade completed) 18. Mailing Address (Street and Not Specify only highest grade completed) 18. Mailing Address (Street and Not Specify only highest grade completed) 18. Mailing Address (Street and Not Specify only highest grade completed) 18. Mailing Address (Street and Not Specify only highest grade completed) 18. Mailing Address (Street and Not Specify only highest grade completed) 18. Mailing Address (Street and Not Specify only highest grade completed) 18. Mailing Address (Street and Not Specify only highest grade completed) 18. Mailing Address (most of working	16b. Kind of Business/Industry
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Shoe Busing 17. Father's Name (First, Middle, Last) 17. Father's Name (First, Middle, Last) 18. M	Ness Mother's Name (First, Middle, 1	Private Maidae Sumama)
Tr. Father's Name (First, Middle, Last) Chaim Axantsov	Ida Dick	
The state of the s		
Susan Bregman (Daughter) 8920 Hilton Hill 20a. Method of Disposition 20b. Place of Disposition (Name of	l Drive, Lanha	m MD 20706
20a. Method of Disposition Burial Secretarion 3 Removal from State	Date	20c. Location - City or Town, Stete
La de de de de la company de l	7 3/29/2004	Beltsville, MD
22. Name and Address of F	Rendon/Hal	e Funeral Home
23a. Par. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such ock, or heart failure. List opty one cause on each line.	is Road, Lanha	
Physician Immediate Cause (Final disease or condition resulting in death) A pue to (or as a consequence of):	iascular di	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		
Cause. Enter Orderrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		
The law required to the set of th		23d. Date of delivery Month Day Year
		bacco use contribute to the cause of death? es 2 No 3 Probably 4 Dunknown
Action of the law requires a signature of the law requires a s	24a. Was a autops perfort	y prior to completion of cause of
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 No Other: 4 Other:	Place of Death Check on on	θ
\$ w 5 0 1 1 res 2 10 NO 1 Inpatient 2 EN/Outpatient 3 DOA 4	Mursing Home 5 Reside	ance 6 ☐Other (Specify) ow injury occurred
The second of the state of the	2 🗆 No	
A Suicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	281. Location (St City or Town	reet and Number or Rural Route Number, n, State)
29a. Certifier of Check only one) 29a. Certifier of Check only one) 29a. Certifier of Check only one) 29a. Certifier of Check only one) 29a. Certifier of Check only one) 3 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, and manner stated	te and place, and due to the ca death occurred at the time, da	ause(s) and manner as stated. ate and place, and due to the cause(s)
29b. Signature and title of certifier 29c. License number 10 10 10 10 10 10 10 10 10 10 10 10 10	1916°	9d. Date signed (Month, Day, Year) Manch 28, 2004
30. Na, e and address of person who completed cause of death (Item 23a) (Type, Print) OM KO Na El Inon OSE	Road Ro	oc vi le MD 20852
State Registrar MAR 3 0 2004 See Signature DHMH 17 Rev 1/2001		

DHMH 17 Rev 1/2001

ORIGINAL

		1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) Harry Odell Sykes, Jr. 4a. Fecility Name (If not institution, give street and number) 2. Date of Death Month Day Year March 24 2004 1:42 A 4b. City, Town, or Location of Death 4c. County of Death
Funeral Director		Prince George's Hospital Cheverly School Security Number 6. Sex 1 X M 2 F 7. Age (In yrs. last birthday) 1 X M 2 F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 1 X M 2 F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 8. Date of Birth (Month, Day, Year) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign of Country) 8. Sep. 8. 1946 9. Wash DC
dis	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit Maryland Prince George's Capitol Heights
n 72 hours after death with the Maryland "natural, or iteme 23a or 28a-f show e-lical Exactiver meat be had the at	by Funeral	
r than "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 Driver 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
h and Mental 7 ie marked c traumatic eve	To Be	Harry O. Sykes, Sr. Lucille Baltimore 19a. Informant's Name/Relationship (Type, Print) Charles D. Sykes - Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5010 Ames St., N.E. Wash., DC 20019
Department of Health Important: If item 27 any injury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park 3/27/2004 21. Sign ure of Funeral Service Licensee 4001 Benning Rd., N.E. Wash., DC 20019
hysician and horizon and but as as the prival-transit	icai Examiner	23a. Parft. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
the attending the for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
5.9	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
is certificate has director, page 2	lon; To Be Completed	24a. Was an autopsy performed? 24b. Were autopsy findings availated prior to completion of cause of death? 1 yes 2 No 1 yes 2 No 1 yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 OA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of Injury Nork? 28d. Describe how injury occurred 28d. Describe how injury
within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEGIRA 50R (ANN) 31. Date filled (Month, Day, Year) MAR 2 9 2004
Stat Registra		31. Date filed (Month, Day, Year) MAR 2 9 2004 Section 1. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6103 AM March Paul Swinson 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Aug. 13, 1930 **Funeral** Birthplace (State or Foreign Country) 1 ☐XM 2 ☐ F Days Hours Min. Director 578-40-9018 73 Wash. DC Usual Residence of Decedent 10a. State 10c. City. Town or Location 28a-f show 10d. Inside City Limits other than "natural, or items 23a or 28a-f showers, the Madical Examiner must be notified at Director 1 XYes 2 No D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3726 Hayes St., N.E. 20019 death Funerai United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married XYes 2 No Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 XNo Specify: δ 3 Widowed 4 Divorced Year or Dates: American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th Construction Work Self-Employed permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any july or other traumatic event, some. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Swinson ပ Dorothy Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dora Swinson - Sister 640 Riverside Dr., #9F, New York, NY 10031 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory 3/25/2004 Clinton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock or heart failu Immediate Cause (Final disease or condition trinfestinel **Physician** resulting in death) /Medical Examiner Cononeny Antery desired theroscherotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death P.O. 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown Deen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has l director, page 2 s autopsy performed 1 ☐ Yes 1 ☐ Yes 2 ☐ No uneral director, 25. Was case referred to medical examiner?

1 20 es 2 \(\text{No} \) Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 1 Yes 2 No s after death 2 Accident filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier the 29b. Sign sture and title of certified 29d. Date signed (Month, Day, Year) 30. Name any address of person who completed cause of death (Item 23a) (Type, Print) i hotfoot James 1300 Picard Dr., #202, Rockville, MD 31. Date filed (Month, Day, Year)
MAR 2 9 2004 State Registrar

			For State Registrar	State	of Mar	yland /		artmen <i>rtificat</i>				lental Hy	giene2	004	121	122
	Physici	an	1. Decedent's Name (First, Middle	e, Last)				_				2. Date of De Month	Day	Year	3. Time o	
,	/Medic			ICHAEL	SAVI	ANO						MARCH	25,	2004	6:52	2 P M
	Examin	er	4a. Facility Name (If not institution			DTMAT				Location o				nty of Death	MEDV	
	Europal		SHADY GROVE 5. Social Security Number	6. Sex		In yrs. last i	birthday)		1 Year		24 Hrs.	8. Date of Bir	th	MONTGO 9. Birth	PIEKY place (State ontry)	or Foreign
Ľ.	Funeral Director		113-32-1516	X □M 2□F	6	2	Yrs.	Months	Days	Hours	Min.	APR. 1	i <i>y, Year)</i> 1 , 194]	I NE	W YORK	ζ ,
	p ,		Usual Residence of Decedent 10a. State 10b. County		1	Oc. City, To	or L	cation					10d. Inside City Limits			
	faryla hov	-0				00. Oky, 10	JWII OI E		перс	BURG						2 No
	28a-	Directo	MD. MONTG	OREKI				10f. Zip		DUNG			10g. Citizen	of What Cou	ntry?	
	death with the Maryland me 23a or 28a-f ehow rmat be notified at		722 OUINC	E ORCHAR	D BI.V	D_#20	1		20	878			ī	J.S.A.		
	deat	Funeral	11. Marital Status	12. Was D	ecedent Ever			Was Deced			gin? (Spe	ecify Yes or No Rican, etc.)		Race - Americal Stack, White,		
36	s after	by Fu	1 Never Married 2 Mar	ried 1 □ Ye	s 21 No Give		1	1 🗆 Yes	_	Specify:	,		Spe	city		
2-0036	72 hours after neturel', or Ite dical Examina		3 ☐ Widowed 4 X Divorced	Year o	r Dates:	16	Sa Dece	dent's Usua	al Occup	ation			16h Kind of	Business/In	HITE	
5	n na	Completed	(Specify only highe	st grade complete			(Give	kind of wo	rk done d	during most	t of worki	ng	TOD. Parid Of	2031103411	dustry	
212	d within giene.	mo	Elementary/Secondary (0-12)	College	e (1-4or 5+)			NO	NE					NONE		
2	be filed within 72 hours after death with the Marylan hat Hygiene. ed other than "naturel", or liteme 23a or 28a-1 show event, the Medical Examinet must be collified at	Be	17. Father's Name (First, Middle,	Last)						18. Mothe	r's Name	(First, Middle	, Maiden Sum	name)		
<u> </u>	should be and Menta Is marked numatic ev	ဥ	ALFRED		VIANO		01 44 11		(5)			NNIE	ARRA		2	
Maryland	s 1 and 2 should of Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relations CAMILLE SAV	TANO/SIS	TED	V						D. #20			,	2087
	Heal Hem 2 other		20a. Method of Disposition	TARO/ SIS	IEK	20b. Place	of Dispo	sition (Nan	ne of			ate #20		n - City or To		. 2007
ê E			1 Burial 2 Cremation 4 Donation 5 Other (S		m State		-	matory or o CREM		1	3-27-	2004	RTVI	ERDALE	. MD.	
altimore,	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service	Liensee	1		2	Name an	d Addres	s of Facilit	v	ME & C				
<u> </u>	89 = 9		W.W. C	ramer	Rell	M000	91 5	801 C	LEVE	LAND_	AVE.	, RIVE	RDALE,	MD. 2	0737	
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. A.7 Due b. Due c. /	n each line. hence to (or as a complete to for a complete to for a complete to complete to for a complete to for a complete to for a complete t	Sclesconsequence on te	ce of):		•			m c	0	e	Approximatinterval Bet Onset and CAMA	tween
Box 68760,	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	d23c. If yes,	outcome of e birth 2 (egnant at tin	pregnancy □ Fetal dea	uth 3	Ectopic pr						Date of delive		Year
o.	t the c by the	hysi	9 Unknown	9□ Ur	known											
_	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditi	ons contributing to	o death but i	not resulting	g in the u	nderlying c	ause give	en in Part I.			obacco use co Yes 2 □ No		ne cause of d ably 4 🗍	
I Records,	The ate h page	Completed										24a. Was autop perfo 1 ☐ Yes		death?	psy findings mpletion of c	available ause of
Vital	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medica examiner?	-				****			of Death	(Check only o	nne)			
	유부를	To	1 ☐ Yes 2 No 27. Manner of Death		☐ Inpatient	2/2 KRV	Outpatier Time o		-	4 🗆 Nu		ne 5 Resid			r)	
Division of	ding After	ertification;	1 Catural 5 Pendin investi 3 Suicide 6 Could	ng (N igation	lonth, Day Y	(ear)	Injury	М		rat ⟨? Yes 2□t	No	28d. Describe				
Σ	i ii e	O	4 Homicide determ	nined 286. Fil	ace of Injury ilding, etc. ((Specify)					ī	28f. Location (: City or Tox	vn, State)			iber,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifyii (Check only one) 2 Medical	ng Physician: To Examiner: On the	the best of a basis of ex anner state	kamination a	lge, deat and/or in	h occurred vestigation	at the time, in my or	ne, date and pinion, deal	d place, a	and due to the ed at the time,	cause(s) and date and place	manner as s e, and due to	ated. the cause(s	5)
	To the within 2 To the comple	Med	29b. Signature and title of certifie		willor 3(a(6)	u.		290	. License	number			29d. Date sign	ned (Month,	Day, Year)	
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	'		30. Name and address of person	who completed c	ause of dear	th (Item 23a	Ad	A	10	to	w i	Dn R	Cocker	110	iys x	0880
	Sta Registr		31. Date filed (Month, Day, Year,	32	Registrar's	s Signature	4	Spa	KN	-69 (1	2			11 6	19.2	000

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** MARVIN В. SCHER 3:05 A. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 X 2 F Director 148-01-0544 87 **NEW JERSEY** 22, 1916 Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show permit. Pages t and 2 should be filed within 72 hours after death with the Marylas Department of Health and Mental Hygiene. Important: if tem 27 is marked other than "natural, or items 23e or 28a-f show eny injury or other traumatic event. It a Mexical Examiner must be multipled at once. 1 Yes 2 □ No Director MD MONTGOMERY SILVER SPRING 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 15115 INTERLACHEN DRIVE, #518 20906 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Tyes 2 Now II If Yes, Give Year or Dates: 1 ☐ Never Married 2 🙀 Married Saltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 ➡ No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 CIVIL ENGINEER U.S GOVERNMENT 17 Father's Name (First Middle | ast) 18. Mother's Name (First, Middle, Maiden Sumame) Be PAULINE **JACOBSON** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLADYS SCHER, WIFE 15115 INTERLACHEN DR., #518 SILVER SPRING, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEMORIL GARDENS 3/31/04 OLNEY, MARYLAND 21. Signature of Funeral Service License DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 1170 ROCKVILLE PIKE, ROCKVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heeft failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician **PNEUMONIA** 3 DAYS /Medical Due to (or as a consequence of): Examiner ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) to the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-transit **ESSENTIAL HYPERTENSION YEARS** Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetel death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) Records, P.O. g t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2X No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Alter Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23958 MARCH 29, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BURT I. FELDMAN, M.D., 3105 N. LEISURE WORLD BLVD., SILVER SPRING, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 2 2004 Jener Registrar

			1_ For State	State of Marylan					0001	10101
			Registrar 1. Decedent's Name (First, Middle, Last	2)	Cel	tificate of De		Re 2. Date of Death	g. No. 1 14	3. Time of Death
Н	Physici		GLORNA	Schere			1	Month MRCH	Dey Yeer	F 11. 51
7	/Medic Examin		4e. Fecility Name (If not institution, give	street and number)		4b. City, Town, or Loc		Meett	4c. County of De	
7					PITAL	ROCKVILLE			MONTGOME	RY
	Funeral Director		5. Social Security Number 6. Se 1578-28-6341	x 7. Age (In yrs. 7. Age 7. Age (In yrs. 7. Age 7.			Under 24 Hrs. lours Min.	8. Date of Birth (Month, Dey,	9. Bi	rthplece (State or Foreign country)
			Usuel Residence of Decedent		0]]1	DEC. 29,	1925 RHC	DDE ISLAND
	arylan	_	10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Ba-f s	Directo	MARYLAND MONTGOMER	Y ROCK	VILLE					1 X Yes 2 □ No
	ath with the Marylar s 23e or 28e-f show	ā	10e. Street and Number	E #1602		10f. Zip Code		10	g. Citizen of What C	ountry?
	ms 23	Funeral	5809 NICHOLSON LAN	12. Was Decedent Ever in U.	.S. 13. V	20852 Vas Decedent of Hispar Yes, specify Cuban, M	nic Origin? (Spec	ify Yes or No-	U.S.A. 14. Race - Am	erican Indian,
ထွ	or Its		1 ☐ Never Married 2 💢 Married	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give			lexican, Puerto R pecify:	ican, etc.)	Black, Wh	ite, etc.
5-0036	hours after death with the Maryland tural", or Items 23e or 28e-f show all Expressional be notified at	d by	3 Widowed 4 Divorced	Year or Dates:						HITE
င်	72	plete	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	ent's Usual Occupation kind of work done durin OO NOT use retired)		7	6b. Kind of Business	i/Industry
212	ed within rejene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	НОМЕМА			O	WN HOME	
and	be filed tal Hygi d other avant, Il	Bec	17. Father's Name (First, Middle, Last)			18.	Mother's Name (First, Middle, M.	aiden Sumame)	
<u> </u>		유	DAVID	SACKETT			SE		ROSENBE	
Mary	ormit. Pages 1 and 2 should spartment of Health and Mer portant: If Item 27 Is marke by injury or other traumatic tas.		19a. Informant's Name/Relationship (Ty STANLEY J. SCHERR/			g Address (Street and I				
ā,	s 1 and Heal		20a. Method of Disposition	20b. P	lace of Dispos	NICHOLSON L ition (Name of eatory or other place)	ANE #100		Oc. Location - City or	RYAND 20852 Town, State
Baltimore,	Pages nent of int: If it		1 Burial 2 □ Cremation 3 □ P 4 □ Donation 5 □ Other (Specify)	removal from State		I. GARDENS	04/01/	2004 0	LNEY, MAR	YI.AND
<u>a</u>	permit. Departr Imports any injs pnce.		21. Signature of Funeral Service Licens			Name and Address of				
n	20E # 3		Donald. C. X	tottlemyer	111	.70 KOCKVIL	LE PIKE,	KOCKAT	LLE, MARY	LAND 20852
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	cations that caused the death		Control of the Contro				Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ		GULL	400-6	ANCE	R	18 MENTHS
	Examiner		Convention to line and distance)	201100 017.					
	p ii	Iner	if any, leading to immediate	Due to (or as a consequ	uence of):					
	s be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ience of):					
	ate be e. sysicien he buria	calE		4	201100 017.					
Q		ed						-0.07		
X Q	leath certific attending pl	an/N	230. Was decedent pregnant	3c. If yes, outcome of pregnar		Ectopic pregnancy			23d. Date of de	
	0 0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4☐ Pregnant at time of de 9☐ Unknown		Other (specify)			Month	Day Year
ŗ	law requires that the de as been signed by the 2 should be detached		Part II. Other significent conditions con	ntributing to death but not resu	afting in the un	derlying cause given in	Part I.	23e. Did toba	cco use contribute to	the cause of death?
cords	n sign	ed by						1 ☐ Yes	2 No 3 P	obably 4 Unknown
000	aw red	Completed						24a. Was an	24b. Were au	itopsy findings available
Ī	The ate h page	Com						autopsy performe 1 Yes 2	d? death?	completion of cause of
VII	Physicien: The ribis certificate har al director, page	Be	25. Was case referred to medical examiner?	loopitate willer			Place of Death (Check only one)		
5		5	1 Yes 2 No		ER/Outpatient 28b. Time of	3 DOA Other: 4	☐ Nursing Home	5 Resident	e 6 □Other (Spe	cify)
VISION	th: After	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work? M 1 ☐ Yes	10	Describe how	injury occurred	
<u>S</u>	ar dea ector by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stre	et, factory, office	28f	. Location (Street	et and Number or Ri	ıral Route Number,
5	itel or rs afte ret Dir led in	Cert						City or Town, S		
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	edical	29a. Certifier (Check only one) 1	sician: To the best of my knowner: On the basis of examinati	wledge, death ion and/or inve	occurred at the time, da estigation, in my opinion	ite and place, and n, death occurred	due to the caus	se(s) and manner as	stated. to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner stated.		29c. License num			Date signed (Monte	
	- 2 - 2		Jan 1 The	and Days		D0061			tratt 31	
	70		30. Name and address of person who con	mpleted cause of death (Item	23a) (Type, P		005			100
			PAUL THAMBI	7707 Media	CALC	TR. DR,	#300	, Rock	VILLE,	MD 20850
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signate	ure &	South		•		

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 30, Dey 2004 **Physician** Gertrude SCHICK 11:00 AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner Hebrew Home of Greater Washington Rockville Montgomery Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 21, 7. Age (In yrs. lest birthdey) If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1□M 2/ F Months Deys 578-20-2628 1922 Washington, DC Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 √Yes 2 No Funeral Director Maryland Montgomery Takoma Park 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 112 Sheridan Ave. 20912 United States Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Real Estate Office 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Rubin Matilda Ellison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marc Schick, Son 112 Sheridan Ave., Takoma Park, MD 20912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 04/01/04 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Garden Falls Church, VA 22. Name and Address of Fecility 21. Signeture of Europeal Servi Torchinsky Hebrew Funeral Home, Inc. 254 Carroll St., NW, Washington, DC 23a. Parl: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. 20012 Approximate Interval Between Onset and Death **Physician** CEREBRAL THROMOSIS Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of) edical Certification: To Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause 24a. Wes an autopsy performed? CHRONIC ATRIAL FIBRILLATION of death? After this certificate has 2 No 1 ☐ Yes 2 ☐ No Division of Vital ours aftar death.

eral Director: After this certifics filled in by the funeral director. or Attending Physician: 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Att within 24 hours aftar d To the Funeral Direct 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29b. Signature and title of contifie 29d. Date signed (Month, Day, Yeer) MO 10 30. Neme and address of person who completed cause of deeth (Ijem 23e) (Type, Print) M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 16 Rev 6/95

		1 - State Registrar	State of Marylar	•	rtificate of		R	eg. No. 20(
nysicia		Decedent's Name (First, Middle, La	David SCHOE	ĽΜ			2. Date of Dea Month	Day Ye	3. Time of Death
Medic: xamine		4a. Facility Name (If not institution, give	re street and number)		4b. City, Town, o	or Location of Death	March 2	27, 2004 4c. County of E	13:25 P
		2626 Henderson Av	renue		Silve	er Spring		Montgo	omerv
neral		5. Social Security Number 6. S	11XIM 2□ F	Ven	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 9.	Birthplace (State or Foreig Country)
ector		144-05-9225 Usual Residence of Decedent	85) 113.			Sept. 28	, 1918 No	ew Jersey
7	_	10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits
allin	ecto	Maryland Montgo	mery	Silve	r Spring				1 ☐ Yes 2 💆 No
Ezamenermust be notified at	Funeral Directo	2626 Henderson Av	enue		10f. Zip Code 2(0902		Og. Citizen of What United St	
NE S	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H	dispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-		American Indian,
all list	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1♥ Yes 2 No		1 □ Yes 2 □tNo	Specify:	Trican, 6(c.)	Specify:	White, etc. white
Called	ed b	15. Decedent's E	Year or Dates: WW I		dent's Usual Occup	ation		16b. Kind of Busine	
Mean	Completed	(Specify only highest gra		(Give	kind of work done of DO NOT use retired	during most of work	ing	U.S. Gove	ernment/Air
	Con		2	Admi	nistrativ	ve Officer	<u>. </u>		storical Off:
	To Be	17. Father's Name (First, Middle, Last,	Samuel Sc	hoem	1	18. Mother's Name Mirian	e (First, Middle, M n Feldma		
		19a. Informant's Name/Relationship (and Number or Rura		•	e, Zip Code)
1	139	Lillian Schoem, W				Ave., Si			20902
6		20a. Method of Disposition 1 Burial 2 Cremation 3	Ji tomoval mom State		sition (Name of natory or other place	ı		20c. Location - City	or Town, State
		* 4 ☐Donation 5 ☐ Other (Specifical Liceroff)			morial Ga . Name and Addres	rdens 03/	29/04	Olney, M	ÍD
once.			/	To	rchinekw	Hebrery Fr	meral H	ome, Inc.	
.		23a. Party Enter the disease, or com shock, or heart failure. List only	plications that caused the deat	h. Do not ente	4 Carroll er the mode of dyin	g, such as cardiac c	Washin or respiratory arre	gton, DC	20012 Approximate
an		Immediate Cause (Final disease or condition	Sa A	1	,				Interval Between Onset and Death
ai er		resulting in death)	Due to (or as a conseq						7 days
	-	Sequentially list conditions,	b. Congest Due to (oras)a consequ		ear + F	affore			9 Days
7	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (orassa consequ	uence or):					
	Exa	resulting in death) Last	Due to (or as a consequ	uence of):					
	ca	(d						
	Physician/Med	IF FEMALE:	00-14	-		·			
	cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
	Jysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	eath 5	Other (specify)				
	by P	Part II. Other significant conditions c	ontributing to death but not resu	ulting in the un	iderlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
1	ed	Alzheiner's	Disease				1 ☐ Ye	s 2 No 3	Probably 4 Unknown
1	Completed						24a. Was an autopsy		autopsy findings available to completion of cause of
							perform 1 ☐ Yes 2	ed? death	? es 2□ No
0	o Re	25. Was case referred to medical examiner?	Hospital:		3 DOA Othe	26. Place of Death			
- I I F	- 1	1 ☐ Yes 2 ☑ No 27. Manger of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	28c. Injury	4 Nursing Hon	ne 5 Resider 8d. Describe how	nce 6 Other (S)	pecify)
1	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work	:? /es 2 ☐ No		,,	
18.4	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office	2	8f. Location (Stre City or Town,	eet and Number or	Rural Route Number,
1 3						l l			
	20	29a. Certifier 1 ✓ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of my known niner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the time estigation, in my op	e, date and place, a pinion, death occurre	nd due to the car d at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	0				29c. License	number	29	d. Date signed (Mo.	nth. Day Year)
		29b. Signature and title of certifier							,, , ,
		29b. Signature and title of certifier	arp, M.D.		139	793	0	Tarde 28	* * * * * * * * * * * * * * * * * * * *
pietery ril	Σ	30. Name and address of person who			Print)			March 28	3,2004

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	1	For State Registrar						ertificate			d Mental H	Reg. I	7111	14	121	+2
	. 1	Decedent's Nam	ne (First, Middle,	Last)				-			2. Date of Month		Day Y	eer .	3. Time o	f Death
cian Iical		WALI		BDUL		SHAH	EED				Apri		2004		407	<u>a </u>
iner	4:		(If not institution,							Location of De	eath		4c. County of			
	L		e George	S HO			er last birthda		leve:	rly If Under 24 F	frs. 8. Date of	Ridh	Princ		eorges	
	Ę	Social Security No. 10 - 10 - 10 - 10 - 10 - 10 - 10 - 10	2860	1 Ø M		52	Yrs.		Days		Jan.	l 8, i	952 W	Count	ingt	
	1	0a. State	10b. County				y, Town or							10	od. Inside C	ity Limits
cto	L	Md.	Prince	Ge	orges	For	est,	/ille								
il Director	1	0e. Street and Nu 1620 T	_{ımber} ulip Av	ve.				10f. Zip 0				_	Citizen <i>o</i> f Wh S.A.	at Coun	try?	
Funeral	1	1. Marital Status		12.	Was Decedent Armed Forces	Ever in U.	S. 1:	3. Was Decede	nt of His	panic Origin?	(Specify Yes or lerto Rican, etc.)	No-	14. Race -	America White, e		
by Ful		1 Never Man	ried 2. Marrie 4. Divorced	d	1 ☐ Yes 2 📈 If Yes, Give Year or Dates:			1 Tes, special	_	Specify:	iono moan, oto.,		Specify:			
Completed	L		15. Decedent's acify only highest	grade co	mpleted)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of						. Kind of Busi	ness/Ind	ustry	
D C		Elementary/Sec	ondary (0-12)	2	College (1-4or	5+)							erizor	า		
		. Father's Name (First, Middle, Last)									Name (First, Mio	dle, Maid	len Sumame)			
To Be		dillie								Emr	na Ma	cAr	thur			
any injury to other traumatic event, I'm Medical Exact and once. To Be Completed by Fur		Pa. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State								ate, Zip	Code)					
		Jerene	Shahee	d/w	ife		162	0 Tul	ip /	Ave. F	orest	/ill	e, Md	. 2	0747	
		20a. Method of Disposition QBurial 2 Cremation 3 Removal from State Comparison Compar									ty or Tov	wn, State				
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		14 16	the disease, or cart filture. List of	dt.	ons that cause	64	4	22. Name and	Address	on 4/2 of Facility 1 dy St	Univers	sal Was	Mortu	ary	C 2 C	te tween
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To Be Completed by Physician/Medical		23a. *art1. Enty shock, or he mmediate Caussisease or conditivesulting in death) Gequentially list or any, leading in death) Gequentially list or any, leading in death) FFEMALE: 23b. Was deceded in the past 1: 1	the disease, or can the lure. List of Final lon onditions, minediate lerlying rinjury is Last on the pregnant 2 months?	b. — c. 23c.	Due to (or as Due to (or as Due to (or as Due to (or as If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown uting to death I	d the death ine. Limitus a consequence of pregnate titme of death to the death titme of death to the death titme of death tit	uence of): uence of): uence of): uence of): uence of): ER/Outpal 28b. Time	22. Name and 11 Ke enter the mode 1. Cyclicular 3. Ectopic pre- 5. Other (spe- enderlying car ent 3. Apola of 28	gnancy crfy)	on 4/1 s of Facility I dy St , such as card NSCSC	Jnivers N.W. diac or respirator 23e. D 1 24a. V a P 1 Ye Death (Check or g Home 5 F	id tobacc Yes Ass an utopsy artormed's 2(3)	23d. Date a Month to use contribution of the price of the	ary on 1	Approxima Interval Best Onset and	te tween Death Year Unknown available
o Be Completed by Physician/Medical Examiner		23a. *art. Entyshock, or he mmediate Causshock, or he mmediate Caussidesase or conditivesulting in death) Sequentially list or any, reading in death) Sequentially list or any, reading in death) FERMALE: 23b. Was decede in the past 1: 1	the disease, or can the lure. List of Final lon onditions, minediate lerlying rinjury is Last on the pregnant 2 months?	b c 23c. Hospitalia	Due to (or as Due to (or as Due to (or as Due to (or as If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown uting to death I	d the death ine. d the death ine. d to the death	uence of): uence of): uence of): uence of): uence of): ER/Outpat 28b. Time Injury	22. Name and 11 Ke enter the mode 1. Cyclic u 3. Ectopic pre- 5. Other (spe	gnancy crity) use gives a Other c. Injury Work 1 Y	on 4/1 s of Facility I dy St , such as card NSCSC	Jnivers N.W. diac or respirator 23e. D 1 24a. V a place of Check or g Home 5 F R 28d. Descri	id tobace Yes As an utopsy arrest (200) yesidence be how in	23d. Date of Month 2 No 3 24b. We price dec. 1 6 □Other	ary on J	Approximal Approximation of Consett and Co	Year Unknown available ause of

State Registrar 31. Date filed (Month, Day, Year) 32
APR 0 2 2004

29b. Signature and title of certifier

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 parket

29c. License number

OCME

29d. Date signed (Month, Day, Year) April 1, 2004

			For State Registrar		artment of Health and N tificate of Death	lental Hygiei	2001 1010
	Physicia		1. Decedent's Name (First, Middle, Last)	Stella SIRKI	S	2. Date of Death Month March 25	Day Year 3. Time of Death 1520 M
)	/Medic Examin	1 4	4a. Facility Name (If not institution, give street a. 1801 E. Jefferson St		4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery
3	Funeral Director		5. Social Security Number 198-01-7286 6. Sex 1 ☐ M 25 Usual Residence of Decedent	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Aug. 1,	
	anyland show	70	10a. State 10b. County	10c. City, Town or Lo	cation kville		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	h the M rr 28a-f rnvtiffe	irecto	Maryland Montgomery 10e. Street and Number		10f. Zip Code	-	Citizen of What Country?
	or death with the Marylar tems 23e or 28e-f show or must be nytitied at	Funeral Directo	1801 E. Jefferson St. 11. Marital Status 12. Wa:		20852		14. Race - American Indian.
036	hours after death with the Maryland Lural', or tlams 23a or 28a-f show al Ezac il et must be mylitied at	þ	1 Never Married 2 Married 1 If You	Yes 2♥ No	Was Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc. Specify: white
21215-0036	be filed within 72 hours after that Hygiene. Id other than "natural", or I event. I've Medical Exact.	Completed	15. Decedent's Education (Specify only highest grade comp. Elementary/Secondary (0-12) Coll	leted) (Give life. I	dent's Usual Occupation kind of work done during most of work DO NOT use retired) Homemaker	ing 16b	. Kind of Business/Industry Own Home
D	should be filed void Mental Hygie marked other that	0	17. Father's Name (First, Middle, Last) Max Sega	<u></u>	18. Mother's Nam	e (First, Middle, Maid othenberg	
Mary	12 shou h and M 7 is mar traumat		19a. Informant's Name/Relationship (Type, Prin		ng Address (Street and Number or Rur		
lore, I	ages 1 and nt of Health i: If item 27		Lisa Thompson, Daughte 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal	20b. Place of Dispo cemetery, cren	Halesworth Drive, sition (Name of natory or other place) 03/2	3/04 20c.	Location · City or Town, State
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury opother traumatic evonce.		. 4 □ Donation 5 □ Other (Specify) 21. Signature c yart (all Service Licensee	22 T	morial Gardens Name and Address of Facility orchinsky Hebrew	Funeral Ho	
H	Physician /Medical		shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death) a.	e on each line. RETERN OSCUPPOTIC	54 Carroll St., Mer the mode of dying, such as cardiac		Approximate Interval Between Onset and Death
8760,	te be executed ysician and be burial-transit about 1	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a consequence of): ue to (or as a consequence of): ue to (or as a consequence of):			
.O. Box 68	ath certif attending for use as	Physician/Med	in the past 12 months?		Ectopic pregnancy		23d. Date of delivery Month Day Year
٥.	w requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions contributing	g to death but not resulting in the u	ndertying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
I Records,	The law reate has bee page 2 sho	Completed				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
Vita	Physician: r this certifica ral director, I	o Be (25. Was case referred to medical examiner? 1 X Yes 2 No Hospital	1 ☐ Inpatient 2 ☐ ER/Outpatien	Othor	(Check only one)	6 □Other (Specify)
n of	ding Physician: The I h. After this certificate ha funeral director, page	\vdash	27. Manner of Death 28a.	Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	
Division of Vital	ten leat lor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of Injury - At home, farm, str building, etc. (Specify)	M 1 □ Yes 2 □ No eet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital or At within 24 hours after d . To the Funeral Direct completely filted in by	edical C	(Check only 2 Medical Examiner: On	To the best of my knowledge, death the basis of examination and/or indidental manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause ed at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
)	To the comp	M	29b. Signature and title of certifier	O (CME)	29c. License number U 157256		Date signed (Month, Day, Year)
	フ		30. Name and address of person who complete	125 Roma is la Pinte	Poorline MO 2085	L	
2	Sta Registr	-	31. Date filed (Month, Day, Year) MAR 2 9 2004	32. Registrar's Signature	Spains		

			1 - For State Registrar	State of Maryla		artment of F			giene	n I.	121.2
	Physic /Medi		1. Decedent's Name (First, Middle, Last Lizzie E.)	Sloan			2. Date of Dea	100	Year	3. Time of Death
	Examii	ner	4a. Facility Name (If not institution, give Doctors Community	Hospital		Lanham	r Location of Death		4c. County Princ		
	Funeral Director		5. Social Security Number 6. Se. 242–46–1386	X 7. Age (In y	rs. last birthday) 96 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept. 3,	, Year) 1907	Count	ace (State or Foreig try) 1 Carolina
	the Maryland 286-f show	rector	10a. State 10b. County Maryland Prince Ge 10e. Street and Number		city, Town or Lo College				10- 0%		od. Inside City Limits 1
	23a or	al Di	7403 Baylor Avenu	le .		1	740		10g. Citizen of W United		-
5-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "neturel", or Items 23a or 28e-f show event, the Medical Examinar must be notified at	d by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ₹ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of Hi f Yes, specify Cuba ☐ Yes 2☐∰No	ispanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- America K, White, e	tc.
-6121	within 72 ene. than "net	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	life. L	lent's Usual Occupa kind of work done o DO NOT use retired Naker	ation furing most of worki)	ng	16b. Kind of Bus		ustry
Maryland 2	9 E D X	To Be Co	17. Father's Name (First, Middle, Last) (unk)	Branch		ilanet	18. Mother's Name (unk)	(First, Middle, i	OWN hor	100	
_	les 1 and 2 should to the stand Ment of Health and Ment if item 27 is marked to the traumetice		19a. Informant's Name/Relationship (Ty. Margaret O'Quinn	-Guardian	7403	Baylor A	and Number or Rura Venue Col	lege Pa	r, City or Town, S rk, Mary	itate, Zip (7land	Code) 20740
Baitimore,	permit. Pages 1 Department of H Important: If its eny injury or oth		20a. Method of Disposition 1 Note: 1 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State		atory or other place	Cem. 4/2/		20c. Location - C Suitland	-	
n n	Depar Impor eny in		21. Signature of Funeral Service License	gwardt	44	100 Powde	Borgwardt r Mill Rd	. Belts	ville M	P.A.	and 20705
	Physician /Medical Examiner	_	23a. Part1. Enter the disease, or complete shock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate		VEUM equence of):	r the mode of dying	, such as cardiac of	r respiratory arre	est,	í	Approximate nterval Between Onset and Death
,00700	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse							
.O. DOX	To the Hospital or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 2 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of preging the second of the second o	tal death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of Month	,	ay Year
cords, r	quires that an signed b	by	Part II. Other significant conditions conditions					23e. Did tob	acco use contrib	ute to the	
וו שבכת	The law re ate has bee page 2 sho	Completed	DEMENTIA	1015M				24a. Was en autopsy perform	prio	or to comp th?	y findings available letion of cause of
V 110	sicien: certific irector,	o Be	25. Was case referred to medical examiner?	ospital: /		045	26. Place of Death	(Check only one			6.10
5	To the Hospital or Attending Physicien: The law within 24 butus after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	ertification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury	at 28		nce 6 Other winjury occurred	(Specify)	
2 .	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, stree	et, factory, office	28	Bf. Location (Stre City or Town,	eet and Number State)	or Aural A	oute Number,
	the Hospi in 24 hou the Funer ipletely fill	edical	29a. Certifier (Check only one) 1 Certifying Physical Cartifying P	cian: To the best of my kn er: On the basis of examin and manner stated.	iowledge, death of ation and/or inve	occurred at the time stigation, in my opin	, date and place, an nion, death occurred	id due to the cau d at the time, dat	use(s) and manne te and place, and	er as state due to the	ed. e cause(s)
1	with Con	Σ	29b. Signature and title of certifier			29c. License			d. Date signed (A		
	Stat		30. Name and address of person who con ADE Roll'S LE AJ 31. Date filed (Moritin, Day, Year)	npleted cause of death (Ite 20/ 32. Registrar's Sign	m 23a) (Type, Pr GK EEND ature	int) SELTRI	217 4415 C-4	REP.	ark M) 2	13748

Registrar

APR 0 2 2004

			1 - For State Registrar	State of	Marylan		artmen <i>tificat</i>			and M	ental Hyg	giene Reg. No.	200	4 12430
i	Physici		Decedent's Name (First, Middle, Last) Elizabeth Viol		1						2. Date of Dea Month March	27, Day	2004	3. Time of Death 1:15P. M
	/Medic Examin		4a. Fecility Name (If not institution, give s Manor Care	street and num	ber)				Spri				County of Dea	ath
	Funeral Director		5. Social Security Number 579-01-8878 6. Sex	M 2□ X F	7. Age (In yrs.	last birthday) 95 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt Month, Day July28	, 190	9. Bi	rthplace (State or Foreign ountry) Chigan
	Aaryland I show	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome	ery	10c. City	y, Town or Lo		ring						10d. Inside City Limits
	with the had a or 28a-1	Direct	10e. Street and Number 2501 Musgrove Road	 I			10f. Zip	Code	20904				zen of What C	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene importants: If item 27 is marked other than "natural; or itams 23a or 28a-f show amounts: If item 23a or 28a-f show any injury or other traumatic avent, the Medical Examinal must be multiled at once.	by Funeral Director		12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Da	ces? No				spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ocify Yes or No- Rican, etc.)		14. Race - Am Black, Wh	erican Indian,
Maryland 21215-0036	within 72 hou lene. than "nature the Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation completed) College (1-	4or 5+)	16a. Deced (Give life. I	kind of wo DO NOT u	rk done d se retired,	<i>luri</i> na most	of worki	ng		nd of Business	overnment
land	uld be filed v Aental Hygie rked other t tic avent, to	To Be C	17. Father's Name (First, Middle, Last) Lucien William S	Swan							(First, Middle, Mable	Maiden		
	ind 2 showaith and h		19a. Informant's Name/Relationship (Ty) Donna Loveless -gre		ce						1 Belts			Zip Code) yland 20705
Baltimore,	Pages 1 and of He Int: If Item		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from S	1 6	Place of Dispo emetery, cren ropoli	natory or c	ther place	atory		9/2004		cation - City o andria	Town, State , Virginia
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service License	Jua	4	4	400 F	owde	<u>r Mil</u>	.1 Rc		svi.	ome, P. lle, Ma	ryland 20705
	Physician		23a. Part 1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition	e cause on ea	used the death ch line. estive				, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death Years
À	/Medical Examiner	L	resulting in death) Sequentially list conditions,	Atri	al Fibr	cillati	lon							
8760,	ate be executed hysicien and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		or as a consequence as a consequence									
.O. Box 687	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		rth 2 ☐ Fetal ant at time of de	Ideath 3□	Ectopic p					2	23d. Date of de	olivery Day Year
Ω.	uires that I signed by Id be deta	þ	Part II. Other significant conditions cor Type II Diabetes M	_		ulting in the u	nderlying o	ause give	n in Part I.			bacco u	_	o the cause of death?
al Records,	: The faw requir cate has been si page 2 should I	Completed									24a. Was a autop perfor 1 Yes	sy med?	24b. Were a prior to death?	utopsy findings available completion of cause of
Division of Vital	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	lospital: 1		ER/Outpatien 28b. Time of Injury		8c. Injury Work	r: 4X Nur	rsing Hor	(Check only or ne 5 ☐ Resid 28d. Describe h	ence 6		acify)
Divis	al or Atters s after dea at Director at Director at in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place o buildin	of Injury - At ho g, etc. <i>(Specif</i>)	ome, farm, str	eet, factor	, office		2	28f. Location (S City or Tow			ural Route Number,
	the Hospital hin 24 hours a the Funeral hpletely filled	edicai (29a. Certifier 1 XCertifying Phys (Check only one) 2 Medical Examin		sis of examina									
)		Me	29b. Signature and title of counter					. License	number US	3			e signed (Mon ch 29,	
	0		30. Name and address of person who co Andrew Kundrat,					Laure	el, Ma	aryl	and 207	07		
	Sta Registi		31. Date filed (Month, Day, Year)		egistrar's Signa	ture &	do	orth						

	1	For State Registrar	State of Ma	aryland /		artment of rtificate of			giene Reg. No.	2004	12431
Physicia		1. Decedent's Name (First, Middle, L Paul Somers, In						2. Date of De. Month April	Day 5	2004	3. Time of Death 4:56 A M
/Medic Examin		4a. Facility Name (If not institution, g					or Location of Dea		4c.	County of Death	
Funeral		775 Ragan Road 5. Social Security Number 6		e (In yrs. last b	irthday)	If Under 1 Yea	r If Under 24 Hi	rs. 8. Date of Bir		Cecil 9. Birth	nplace (State or Foreign untry)
Director		229-03-1457 Usual Residence of Decedent	1 X M 2 □ F	88	Yrs.	Months Days	Hours Mi	n. January	29,	1916	VA
nyland how		10a. State 10b. County		10c. City, To							10d. Inside City Limits 1 ☐ Yes ※☐ No
the Ma	ecto	MD Cecil 10e. Street and Number		Cono	wing	10f. Zip Code			10g. Citiz	en of What Co	
th with 23a or	a Di	775 Ragan Road				2191	8		us	A	
BAITIMOFE, MARYIAND ZIZID-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merial Hygiene. Department of Health and Merial Hygiene. Department of Health and Merial Hygiene. Example of Health and Merial Health and Health a	by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 MYes 2 N If Yes, Give Year or Dates:	No		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🕱 No		(Specify Yes or No erto Rican, etc.)		A. Race - Amer Black, White Specify: Wh	
n 72 ho	Completed	15. Decedent's (Specify only highest)	grade completed)		(Give	dent's Usual Occi kind of work don DO NOT use retii	e during most of w	vorking	16b. Kir	nd of Business/I	ndustry
Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z	Somp	Elementary/Secondary (0-12)	College (1-4or 5	+)	Cox	llege Pr				iversit	у
VIZING Mental Hy	To Be	17. Father's Name (First, Middle, La Paul Somers	st)				Unknow				
Mary id 2 sho lith and lith 27 le mu		19a. Informant's Name/Relationship Anthony Dralle,		19				Rural Route Numbe anardsvil			
or Heal		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3		20b. Place cemel		sition (Name of matory or other p	1	Date 09-2004	_	cation - City or	
altimore, mit. Pages 1 al partment of Hea portant: If item y injury or othe		* 4 □Donation 5 □ Other (Spe	city)	R. T.	Foo	urd Fune 2. Name and Add	ral Home	, P.A.	Ri	sing Su	n, Maryland
Depa Depa Impo eny is		21. Signature of Funeral Service Lie	Jood.	il			een Stree	k.I. Foar et, Risin	a fu g Su	nerax H n, MD 2	ome, P.A. 1911
Physician		23 Pa. 1. Enter the disease, or constitute. List or Immediate Cause (Final disease or condition	omplicate as that causally oxecuse on each line. MYOCARD				ying, such as card	iac or respiratory a	rest,		Approximate Interval Between Onset and Death UNKNOWN
/Medical Examiner		resulting in death)	Due to (or as	a consequenc	e of):						
l po is	iner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	Due to (or as	a consequenc	e of):						
te be executed ysician and le burial-transit	cal Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequenc	e of):						
9 % 9			d		- 5						
Records, P.O. Box 68 The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea		Ectopic pregnar Other (specify)	су		2	3d. Date of deli Month	very Day Year
rdS, P.	by	Part II. Other significant condition	s contributing to death b	ut not resulting	j in the u	nderlying cause (given in Part I.				the cause of death?
	Completed							24a. Was autor perfo 1 Ves	osv	prior to death?	topsy findings available completion of cause of
Vital sician: T certificat rector, pa	o Be (25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 ER/	Outnatia	3 7 704		eath <i>(Check only o</i> Home 5X Resi		TOther (See	5,255,(42,570))
ald this	\vdash	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Inju (Month, Da		Time of Injury	f 28c. In		28d. Describe			sity)
	Certification;	3 Suicide 6 Could no 4 Homicide determin	t be Geo Blood of Ini	ury - At home, c. (Specify)	farm, st	reet, factory, offic	8	28f. Location (City or To			ral Route Number,
Division of the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best xaminer: On the basis o and manner st	f examination	lge, deat and/or in	h occurred at the vestigation, in my	time, date and pla opinion, death of	ace, and due to the courred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
To th withir To th comp	M	29b. Signature and title of certifier	11)		4	nse number			e signed (Month	
		30. Name and address of person w	Hernand	leath (Item 23:	a) (Type		27578			4-5-04	<u> </u>
6+1		Avelina Hernan	dz, MD VA	Marylar	nd H		re Syste	m, Perry	Poin	t, MD 2	1902
Sta Registr		31. Date filed (Month, Day, Year) APR 1 2 2	32. Registr	rar's Signature	A STATE OF THE STA	and a					

			_ rui	Department of Health and	Mental Hygiei	ne	101-
			The glott of	Certificate of Death		No. CUUL	3. Time of Death
	Physici	an	1. Decedent's Name (First, Middle, Last) Marjorie B. Sales		2. Date of Death Month	Day Year	9:00 PM
	/Medic	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deatl	1 7	4c. County of Death	1/-00
	Examin	ier	SACRED HEART HOSPITAL	CUMBERCA		ALLEGA	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	thday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birth	place (State or Foreign
	Director		21.7-20-3340 /1	Yrs.	June 9,	1932 Mary	land
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
	Maryli f sho	jo	MD Garrett Frier	ndsville			1 ☐ Yes 2 No
	be filed within 72 hours after death with the Maryland at Hygiene. A let Hygiene do they than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be notified at	Funeral Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?
	th witi	aiD	2806 Friendsville Road	21531		USA	
	ems ems	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,	
2	s afte	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 💆 No If Yes, Give 3 🛣 Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: V	white
Š	hour tural	ed b		Decedent's Usual Occupation	16b	. Kind of Business/Ir	ndustry
2	in 72	Completed	(Specify only highest grade completed)	(Give kind of work done during most of wor life. DO NOT use retired)	king	. Tallo of Doonlood	iddolly
7	d with giene er tha	Com	Elementary/Secondary (0-12) College (1-4or 5+) 2 years Ho	omemaker		Own Home	
2	e file al Hyg I othe vent,	Bec	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid		
2	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental Mental and the Ment	To	Clayton M. Frazee		iet E. Enl		
2	s 1 and 2 should be filed within 72 hours after death with the Maryla if Healith and Mental Hygiene. If Healith and Mental Hygiene is flem 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Exam her must be notified at			Mailing Address (Street and Number or Au BO6 Friendsville Rd.			^{Code)} 21531
ב ט	1 and Health Iem 27 other tr		20a Method of Disposition 20b. Place of	Disposition (Name of		Location - City or To	own, State
2	Pages nent of it int: If ite		1 1 A Burial 2 Cremation 3 Hemoval from State	y crematory or other place) d Cemetery, April 8,	2004 Oa	kland, MD	
	- 5 2 5		21. Signature of Funeral Service Ligensee	22. Name and Address of Facility Newman Funeral Hom			
בֿ	Depar Depar Impo any ir		Du Lun Damaco	Newman Funeral Hom 179 Miller St., Gr			
Ī			23a. Part1. Enter the disease, or complications that caused the death. Dor shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,	110 2100	Approximate Interval Between
ı	Physician		Immediate Cause (Pine)	earl Failure			Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of				- 1.0.0
	Examiner	_	Sequentially list conditions, if any, leading to immediate b. Cudio myo pu				2 years
	pe sit	Examiner	if any, leading to immediate Due to (or as a consequence of cause. Enter Underlying Cause (Disease or injury	от):			
2	xecut and al-trar	xan	that initiated events c	of):	·		
	cate be executed hysician and the burial-transit	dical E	L _d				
	ifficate g phy as the	ledic	<u> </u>				
5	death certifica attending ph d for use as ti	M/us	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Date of delive	
:	e deat he att	Physician/Me	1 Yes 2 No 4 Pregnant at time of death	5 Other (specify)		Month	Day Year
	d by the	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in	the underlying square given in Red I	23a Did tohace	o use contribute to t	he cause of death?
'n	ires th signe 3 be d	l by	Renul Fui we	the underlying cause given in Fait i.	1 ☐ Yes		1/
5	requ been should	Completed	10114				
ב	ne law has l	mpl			24a. Was an autopsy performed?	prior to co death?	psy findings available mpletion of cause of
<u></u>	n: Th ficate or, pag	e Co	25. Was case referred to medical	00 Discos (Dec	1 Yes 2 1		212 No
>	sicia s certi	0 0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	Other	th (Check only one) ome 5 - Residence	6 □Other /Specif	ivl
5	g Phy er this ieral c	n: T	27. Manner of Death 28a. Date of Injury 28b. T	ime of 28c. Injury at Work?	28d. Describe how in		
5	andin ath. pr: Aft	atio	2 Accident investigation	M 1 Yes 2 No			
2	r Atte	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Street City or Town, Sta		I Route Number,
2	urs af ral Di						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Atten this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifying Physicien: To the best of my knowledge (Check only 2 Medicel Examiner: On the basis of examination and manner stated.	, death occurred at the time, date and place d/or investigation, in my opinion, death occu	and due to the cause rred at the time, date a	(s) and manner as s and place, and due to	tated. the cause(s)
	o the ithin 2 o the omple	Med	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month,	Day, Year)
	⊢≯⊢ŏ		Norsock Shi MD	Doc 55 325	A	pril 06,	2004
	_		30 Name and address of person who completed cause of death (Item 23a) (Type Print)			
	5		WONGOCK SHEN MD 48 TOWN TEN	race Frosthwag	MD215	32	
	Sta		31. Date filed (Month, Day, Year) 32. Hegistrar's Signature				
	Registr	ar	APR - 8 2004	Contract of			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			Amer	nd Item	#5 per find	830°	4728784 8	epar as Cert	ificate of	Death			004	12433		
	Physician /Medica	1	Rowena	-	, Last) Pearl	Str	atton				2. Dete of De April		4 Year	3:30 AM		
1	Examine	4a	Fecility Neme (If ennett								_	4c. County of Deeth arrett				
	Funeral Director		5. S S14_Seyri1 (347) er 514-07-10/10		6. Sex 1 ☐ M 2 ☒ F		yrs. lest birthday) ff Under 1 Year ff Under 24 Hrs Months Days Hours Min.			8. Date of Birth (Month, Day, Year) Aug. 23, 1918 Ka			lace (State or Foreign try) as			
Baltimore, Maryland 21215-0020	ylend Mor	Usuel Residence of Decedent									0d. Inside City Limits					
	Mar Mar	Į	KY	And	erson	Lawrenceburg								1 M Yes 2 No		
	iter death with the Mar r thems 23s or 28s-f si wher must be notified	10e	10e. Street end Number 209 Saffel St.					10f. Zip Code 40342					10g. Citizen of What Country? USA			
	urs e	5	Marital Status 1 ☐ Never Marrie 3 🕅 Widowed	12. Wes Dec Armed F 1 Yes If Yes, G Year or I		J.S. 13. Was Decedent of Hispanic Origin? (Specify Yes if Yes, specify Cuban, Mexican, Puerto Rican, e 1 □ Yes 2 ₩ No Specify:				No- 14. Race · American Indian, Black, White, etc. Specify: White						
	ed within 72 horygiene. For then "neture It, the Medical It.	Polarie E	(Special		t grade completed, College (16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher				16b. Kind of Business/Industry Elementary Education			
D	亚工士号 。								18. Mother's Na	me (First, Middle	ne (First, Middle, Maiden Surname)					
an	Mental H Mental H Brice off	Da	nie1		- Bra	ndt				Della	Marg	aret	Oue:	llhorst		
ary	3395		. Informant's Na	me/Relationsh	nip (Type, Print)		19b.	Mailing	Address (Stree	t and Number or F						
ž	47 th	M	argaret	Collin	ns/Daught	er	34	0 W	arnick	Way, Oak	Land, Ma	ry1 a nd	21550	O		
imore,	nit. Peges 1 en ertment of Heal ortant: if Item 2 injury or other	20a	Margaret Collins/Daughter 340 Warnick Way, Oakland, Maryland 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) Lawrenceburg Cemetery 4/8/04 Lawrenceburg, KY													
Balt	Departi Departi Import eny inj ance.	21.	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Stewart Funeral Home 32 S. Second St., Uakland, Maryland 21550													
	Physician	23	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death													
	/Medical Examiner	dis	Immediate Cause (Final disease or condition atherosclerotic cardiovascular disease 1 year													
			resulting in death) Due to (or as a consequence of):													
,09	ificete be executed g physicien end es the bunel-trensit	Sec if a cau Cau	quentially list con ny, leading to imi se. Enter Under use (Disease or in initieted events	ditions, mediete tying njury	c	Due to (or as a consequence of):										
ox 68760,	E 000	res	that initieted events resulting in death) Last Due to (or as a condition of the condition						nsequence of):							
Box	atte d for	Part	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did	23b. Did tobacco use contribute to the cause of death?				
P.O.	that the death certied by the attending deteched for use of Physician M		hronic anemia, valvular heart disease								1 🗆	Yes 24 No	3 ☐ Prob	pably 4 □ Unknown		
cords	The law requires that the death certificate has been signed by the attending pege 2 should be deteched for use as Completed by Physician MA.		congestive heart failure									an autopsy rmed?	ava	ere autopsy findings allable prior to impletion of cause death?		
æ	0 - 5										101	Yes 2⊠No	1 🗆	Yes 2□ No		
Division of Vital Records,	Iclan: The certificate rector, peg	25.	Was case referre	ed to medical						26. Place of De	ath (Check only o	one)				
	Physician: this certificated director,		examiner? 1 🗆 Yes - 2 🗖 N	40	Hospital: 1 🗆	Inpatien	t 2 ER/Out	patient	3□ DOA Ot	her: 4 Nursing I	ome 5 Residence 6 Other (Specify)					
	Attending Ph or death. ector: After th by the funeral		Menner of Death IAD Natural 2 ☐ Accident	5 Pending	etion		28b. Time of 28c. Injury at			28d. Describe	28d. Describe how injury occurred					
Divis	tal or Attending P rs efter death. al Director: After t led in by the funere Certification:		3 ☐ Suicide 4 ☐ Homicide	6 Could n determi							28f. Location (Street and Number or Rural Route Number, City or Town, Stete)					
	ne Hospi n 24 hou ne Funer pletely fill	29a. Certifier (Check only one) 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.											the cause(s)			
D	To the company	29b	29b. Signature and title of certific.				29c. License number D0025759					29d. Date signed (Month, Day, Year) April 2, 2004				
			30. Neme end address of person who completed cause of death (Item 23e) (Type, Print) Walter K. Naumann, M.D., PO box 247, Accident MD 21520													
State Registrar 31. Date filed (Month, Day, Year) 5 2004 32. Tegistrer's Signature																

			For State Registrar	11040	State of	Marylan	d / Depa	rtment tificate	of H	ealth and	Mental H	ygiene Reg. No	200!	1 1 loss y 5
-	D		1. Decedent's Name	•							2. Date of Month	Death Da 18	y Year	3. Time of Death
	Physicia /Medic	al	Mary Lid								March		2004 County of Dear	1:45 P
	Examin	er	4a. Facility Name (If							Location of Deat	h		, , , , , ,	
			Homewood 5. Social Security N		nent Cent	er . Age (In yrs.	last birthday)	Will:		Port If Under 24 Hrs	8. Date of	Birth Day, Year)	ashingto	JII hplace (State or Fore juntry)
165 t	Funeral Director		214-09-7 Usual Residence of	848	1□M 2 ∑ F	94	Yrs.	Months	Days	Hours Min.	08/03	Day, Year) /1909	Co	MD
	yland		10a. State	10b. County			y, Town or Lo							10d. Inside City Lim
	Ba-fa	cto	MD	Washi	ngton	Wil	laimspo					T -		1 □ Yes 2 🔀
9	th with the Maryland 23e or 28e-f show	ai Director	10e. Street and Nur 16505 Vi		Ave.			10f. Zip 217	95			USA		
7	ems 23	Funerai	11. Marital Status		12. Was Deced	dent Ever in U des?	.S. 13. V	Vas Deced Yes, spec	ent of Hi	ispanic Origin? (S in, Mexican, Puer	pecify Yes or to Rican, etc.)	No-	14. Race - Ame Black, Whit	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat near the usuiting all angre.	by	1 ☐ Never Marri 3 🔯 Widowed		If Yes, Give Year or Da)		☐ Yes 2		Specify:		100	Specify: W	
5-6	nate	ete	(Spec	15. Decedent's ify only highest	Education grade completed)		16a. Deced	lent's Usua kind of wor DO NOT us	k done d	ation during most of wo f)	rking	16b. K	(ind of Business	industry
121	within ene. then "	Completed	Elementary/Seco	ndary (0-12)	College (1-	4or 5+)	Homer			"			Home	
70	Hygie Hygie other ant, it		17. Father's Name	(First, Middle, La	st) 4		Homei	ilaket		18. Mother's Na	me (First, Mide	dle, Maidei		
an +	d be sed o c eve	To Be	Harry Ke	efer Ra	msburg					Katheri	ne (un	k) Mo	ngan	
Z Z	should nd Men marke umatic	F	19a. Informant's Na				19b. Mailin	g Address	(Street a	and Number or R	ural Route Nur	nber, City	or Town, State,	Zip Code)
<u> </u>	and 2 saith a n 27 is		Janis E.	Ramsbu	rg/Sister	-in-law	₹ 16505	Viro	inia	a Ave. Ar	t. A11	0, Wi	11iamsp	ort MD 21795
(J) 5	S 1 a of Hei		20a. Method of Disp	position		20b. F	Place of Dispo- cemetery, cren	sition (Nam	ne of ther plac	ce)	Date	20c. L	ocation - City or	Town, State
<u>~</u> ₽	Page nent o nt: M		1 XBurial 21 1 4 □Donation		☐Removal from S cify)					ry 03/2	20/2004	Hag	erstown	, MD
Baltimore	permit. Departmitimporte any Inju		21. Signature of Fu	ineral Service Li	nse									neral Hom
') m	Depa impo any l		N Tay	any	1. De	nito				comac Sti			town, M	D 21740
	Physician Physician		shock, or hea Immediate Cause disease or condition	irt failure. List or (Final	plications that canly one cause on ea	used the deal		er the mod	_		c or respirator	y arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		Due to (or as a consec								,
1	snsit	miner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	inditions, nmediate ertying injury	Due to (d	or as a consec	quence of):							
, 09,	e be executed /sician and e burial-transit	cal Examin	resulting in death)	Last	Due to (or as a consec	quence of):							
687	certificate iding phys ise as the													
Box	atter for u	Physician/Medi	IF FEMALE: 23b. Was deceden in the past 12 1 \(\superscript{Yes}\) 2 (months?		nth 2 ∏ Feta ant at time of o	al death 3	Ectopic pr Other (sp		,		_	23d. Date of de Month	livery Day Year
C.A.	w requires that the deben signed by the should be detached	Phy	9 Unknown		s contributing to de	ath but not res	sulting in the u	nderlying c	ause giv	en in Part I.	23e. D	id tobacco	use contribute to	the cause of death?
1 sp.	requires I	Completed by	Huger	Juscon							1	∏Yes 2	⊠ No 3□P	robably 4 Dunkno
ecord	law rec as bee	jete	Conce	or 415.	Hart de	500					24a. W		24b. Were a	utopsy findings availa
O E	sician: The law certificate has k irector, page 2 s	E	ARC	10000	10/10						1 □ Ye	itopsy informed? s 2/X/N	death?	2 No
Tal C	an: rtifica stor, p	Be C	25. Was case refer	rred to medical	USC					26. Place of De				
چر	Physici this cerral direc	ToB	examiner?	No	Hospital: 1 🗆 li	npatient 2	ER/Outpatier	1 3 DC	Oth Oth	er: 4 Nursing	Home 5□R	esidence	6 ☐Other (Spe	cify)
OLO Ion o	Attending Physical Colors After this by the funeral di		27. Manner of Dea 1. Natural 2 Accident	th 5 🗆 Pending investiga		f Injury h, Day Year)	28b. Time or Injury	f M	28c. injur Wor 1 🗆	yat k? Yes 2 □ No	28d. Descri	oe how inju	iry occurred	
Divis	of or Attend after death Director: d in by the f	ertifica	3 Suicide 4 Homicide	6 Could no determin	286. Place	of Injury - At h	nome, farm, str ify)	eet, lactor	y, office			n (Street a Town, Stai		ural Route Number,
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical Certification:	29a. Certifier (Check only one)	Certifying	Physician: To the xaminer: On the ba	best of my kn isis of examin ier stated.	owledge, deatl ation and/or in	n occurred vestigation	at the tir	me, date and place opinion, death occ	e, and due to I urred at the tin	he cause(s ne, date ar	s) and manner a nd place, and du	s stated. e to the cause(s)
	within 2 within 2 To the comple	Me	29b. Signature and	d title of certifier	1//			290	c. Licens	se number		29d. D.	ate signed (Mon	th, Day, Year)
			•	/10/1	1) -				De	2680	6	1	loch !	18,209
	\swarrow^{γ}		30. Name and add	reds of person w	no completed caus	e of death (Ite	m 23a) (Type,	Printy		4-	25/2	•	nan >	>/7.42
1	9,		Mu)	Now	14)/	gistrar's Sign	ton 1	Yu	2	110.96	MAC	ch 6	IVVI C	1182
	Sta Regist	ate	31. Date liled (Moi	"MAR" 1'S	2004 32.7	Billian S Sign	1. 1	perte	1					

		For State Registrar	State of Ma	ryland / [Departme <i>Certifica</i>			Mental Hy	/giene Reg. No.	200	4 12
Physicia		1. Decedent's Name (First, Middle, Last)						2. Date of D Month	Day	Year	3. Time of D
/Medic		Stanley Herbert S 4a. Facility Name (If not institution, give:			, 4b. Ci	ity. Town, or I	ocation of Dea	marc	-	County of Oe	
Examin	er	Fahrney-	Keedy	Nursing	Home B	SOON!	sbord		N	Jash	ing to
uneral irector		5. Social Security Number 220–18–3376 6. Security Number 152	7. Age	(In yrs. lashbir 76	Yrs. If Unc	der 1 Year ns Days	Hours Min	8. Oate of B (Month, D Aug.	irth $_{av.\ Year)}^{av.\ Year)}$	9. Bi	irthplace (State or Country) aryland
*	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location						10d. Inside City
Important: If item 27 ie marked other then "naturel", or iteme 23a or 28e-f ehow any injury or other traumatic event, the Medical Examinat must be notified all once.	tor	Maryland Washin	gton		Hagers	stown					1 🗆 Yes
and a	Director	10e. Street and Number			10f. 2	Zip Code				en of Whal C	Country?
Mark	rai	1646 Woodlands Ru			12 W D-		1742	Consider Van er N		JSA 4 Bace - Am	nerican Indian,
	by Fur	11. Marital Status 1 Never Married 2 A Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ∑Yes 2 □ N If Yes, Give Year or Dates:			pecify Cuban	Specify:	Specify Yes or N to Rican, etc.)		Black, Wh	
	Completed	15. Oecedent's Edu (Specify only highest grad	cation	16a.	Oecedeni's U	sual Occupat	ion uring most of wo	orkina	16b. Kin	d of Busines	s/Industry
86	mple	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DO NOT	Tuse retired) inter		······· y	207	ernmen	nt
	S	17. Father's Name (First, Middle, Last)	0				18. Mother's Na	me (First, Middle			
	To Be	Edwin Stanley Sou	ders				Li11:	ian Barb	ara M	leussne	er
	-	19a. Informant's Name/Relationship (Ty Deborah Campbell						ural Route Numi Sykesvi			
5		20a. Method of Disposition		20b. Place o	Disposition (A	Name of or other place	,	Date	20c. Loc	cation - City o	r Town, Slate
		1X Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)			Hill			18/04	Wa	ynesbo	ro, Pa.
once.		21. Signature of Funeral Service Licens	99 NN	7 -		and Address	1	INNICH			
a 0		23a. Part1. Enter the disease, or compl	/////	the death Do				d., Hag		wn, Md	Approximate
5		shock, or heart failure. List only of Immediate Cause (Final	ne cause on each lin	e.	not enter the m	iode of dying.	30011 03 021010	or respiratory	211000,		Interval Betw Onset and De
an al er		disease or condition resulling in death)	a. Due to (or as a	a consequence	of):						1 8 M
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause juissase or injury	Due to (or as a	a consequence	of):						
3	ai Examiner	that initiated events resulting in death) Last	Due to (or as a	a consequence	of):						
	ledic		J								
	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic 5 □ Other	c pregnancy (specify)			2:	3d. Date of de Month	elivery Day Ye
	d by Ph	Part II. Other significant conditions co.	ntributing to death bu	ut not resulting i	n the underlyin	g cause giver	n in Part I.				to the cause of de Probably 4 ⊠Ùr
	Completed							24a. Wa		24b. Were a	autopsy findings a
b	ошь							perf	ormed?/	death?	completion of car is 2 No
iiecios, page 2 s	Be C	25. Was case referred to medical examiner?						ath (Check only	one)		
	ို	1 ☐ Yes 2 ☑ No		nt 2 ER/O				Home 5 Res			ecify)
	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Year) 285.	Time of njury M	28c. Injury Work 1 🗆 Y	at P es 2 □ No	28d. Describe	now injury	occurred	
, yo 111 De	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ury - At home, fa c. (Specify)	irm, street, fact	tory, office			(Street and own, State)	Number or F	Rural Route Numb
completely filled in by the funeral director,	Medical		sician: To the best oner: On the basis of and manner sta	examination ar							
	ž	29b. Signature and title of certifier				29c. License	number		29d. Date	signed (Mon	nth, Day, Year)
		30. Name and address of person who come address of person who come and address of person who come add	===			005 2	323		3//	1164	
		30. Name and address of person who co	ompleted cause of de	eath (Item 23a)	(Type, Print)	al 04.	7/	and staring	~ m	£2	1742
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¥.	/Media	al	Gladys Anna Mae S 4a. Fecility Name (If not institution, give s			4h City To	wn, or Location of	April	5 20 4c. County	004 0910	IV!
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	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1	Year If Under 2			Birthplace (State or Fore Country)	B <i>ign</i>
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	or 28g	Director	10e. Street and Number			10f. Zip Ci	ode		10g. Citizen of W	/hat Country?	
	23a c	<u>e</u>	11 E. Poplar Stre	et		217	'34		USA	A	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Examiner must be mailfied at	by Funeral I	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:			it of Hispanic Orig Cuban, Mexican, No Specify:	in? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race Black Specify:	e - American Indian, k, White, etc. White	
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<u>a</u>	w requires that I been signed by should be detai	ed by Ph	Part II. Other significant conditions cond	tributing to death but not resu	lting in the u	nderlying caus	se giyen in Part I.			bute to the cause of death?	
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Division of	는 등을	H- 1	27. Mann Death 1 atural 5 Pending 2 Accident investigation		28b. Time of Injury		Injury at Work?	28d. Describe	how injury occurre		Ī
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	he Hospit n 24 hour ne Funera	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	ician: To the best of my know er: On the basis of examinati and manner stated.	vledge, deatl on and/or in	n occurred at t vestigation, in	he time, date and my opinion, death	place, and due to the occurred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)	
	To the within 2 To the complet	M	29b. Signature and title of certifier	7- 1-		1	cense number		29d. Date signed	(Month, Day, Year)	
7	6		- frankflux	ede			27898		4/5/0	4	
1	H-10		30. Name and address of person who con FRAO CISCO L. AHD	npleted cause of death (Item ADE 350	23a) (Type, 1116	ST. /	46ESTOU	N, MD 21	740		
4	Sta Registr		31. Date filed (Month Pan Year) 200	32. Bibgistrar's Signat	y. A	arthe		j			

State of Maryland / Department of Health and Mental Hygiene 2004 12437 Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Robert Carlton SWOPE April 0633 AM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 8. Date of Birth (Month, Day, Yea, May 13, 1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Days Hours Min. 1**⊠** M 2□ F 220-18-3358 77 1926 Director Pennsylvania Usual Residence of Decedent the Maryland worke 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28e-f ehov other traumetic event, the Medical Evanirat must be nullified at 1X Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1633 Edgewood Place 21740 USA death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ՃYes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. other than "r Elementary/Secondary (0-12) 12 College (1-4or 5+) car inspector railroad it 2 should be filed with and Mental Hygier 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Geraldine Woolridge John W. Swope, Jr. ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ges 1 and 2 it of Health i Peggy L. Swope - wife 1633 Edgewood Place, Unit 3, Hagerstown, Md.21740 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 4/2/04 Hagerstown, Maryland 22 Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licensee 15 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, of complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) CELL LYMPHOMA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 certificate be Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 99 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 🗆 No 1 Yes the Hospital or Attending Physician: nin 24 hours after death. the Funeral Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital: 1 Am atient 1 Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA funeral 28a. D te of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital c within 24 hours at To the Funeral D completely filled i 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) Sician HAGURSTOWA, 31. Date filed (Mont) State Registrar

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)	To Cor	~	29b. Signature and title of celtifier 30. Name and address of person,who completes	eted cause of death (Item 23a)	(Туре,	C	License	440			ead. Date sig	aned (Month, L	10 4
el el	Sta Registi		31. Date filed (Month, Day, Year) APR 0 9 2004	32. Registrar's Signature	500		4)1	Ty.	HVC	H	Dul	achs,	101) 2140,

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death

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Examiner To the Hospital Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician. The law requires that the death certificate be executed completely filled in by the funeral director. Also the spens signed by the attending physician and completely filled in by the funeral director. Also the funeral director. Also the spens signed by the attending physician and completely filled in by the funeral director. Also the spens signed by the attending physician and completely filled in by the funeral director. Also the funeral director	Physicia /Medic		MARI
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1 - For State Registrar	Otate of Warya		rtificate of l		Reg	J. No.	
1. Decedent's Name (First, Middle, L					2. Date of Death Month	Day Ye	3. Time of Death
MARIE	SALAMON		· · · · · · · · · · · · · · · · · · ·	·	APRIL 5,		1:00P M
4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or	Location of Death		4c. County of [
CROFTON CONVALES			CROF	TON If Under 24 Hrs.			RUNDEL
	Sex 7. Age (In yr.	s. last birthday) 2 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	(ear)	Birthplace (State or Foreign Country) IEM TEDCEV
153-12-4898 Usual Residence of Decedent					NOV 29,	1921 1	NEW JERSEY
10a. State 10b. County	10c. (City, Town or Lo	ocation				10d. Inside City Limits
NJ HUDSON	т	KEAR	NEV				1 X Yes 2 ☐ No
10e. Street and Number		KLITIK	10f. Zip Code		100	g. Citizen of Wha	t Country?
425 BEECH STREE	rт		0703	2		USA	4
11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of H		ecity Yes or No-		American Indian,
1X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No	i			Hican, etc.)		White, etc. WHITE
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	MILLE
15. Decedent's (Specify only highest of	Education	16a. Dece	dent's Usual Occup	ation	ring 16	5b. Kind of Busin	ess/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)	9		
12		C	LERK			TRUST (COMPANY
17. Father's Name (First, Middle, La.					e (First, Middle, Ma		
JOSEPH SALAMO	N.			MARY	Y BORKONS	KI	
19a. Informant's Name/Relationship KAREN H. KLOCKO			ng Address (Street OLD POST		OFTON, MD		te, Zip Code)
20a. Method of Disposition			osition (Name of matory or other place		Date 20	oc. Location · Cit	y or Town, State
1 XBurial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Special Control of Contro		,	OLN CEMET	· · · · · · · · · · · · · · · · · · ·	/2004	BRENTWO	D, MD
21. Signature of Funeral Service Light	,,		2. Name and Addre	es of Facility		EVANC E	INEDAT HOME
> Keld	24		16000 ANN		JBERT E. JAD BOWI		JNERAL HOME 20715
resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hyper to or as a cons b. Hyper to or as a cons c. Carclic Due to (or as a cons d.	equence of):	e Cano	lio Vac	culari G	iseus	y gen
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pre∉ 1 □ Live birth 2 □ Fr 4 □ Pregnant at time of	etal death 3	□Ectopic pregnancy	,		23d. Date o Month	
Part II. Other significant conditions	s contributing to death but not	resulting in the t	underlying cause giv	en in Part I.	23e. Did toba	-	ite to the cause of death? Probably 4 Unknown
		···			24a. Was an autopsy performe	ed? prio	re autopsy findings available r to completion of cause of th? Yes 20 No
25. Was case referred to medical				26. Place of Dea	th (Check only one		
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	ent 3 DOA	er: 4 Nursing H	ome 5 Residen	ice 6 Other	Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Wor	y at k? Yes 2 □ No	28d. Describe how	v infury occurred	
3 Suicide 6 Could no determin	be 290 Place of lower A	t home, farm, st ecify)	treet, factory, office		28f. Location (Stre City or Town,		or Rural Route Number,
	Physician: To the best of my laminer: On the basis of examiner and manner stated.						
29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (/	Month, Day, Year)
Rakes	handle	1 M	DID	2010	9 C	4/1	104

State Registrar

RAKESH ARORA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



			State of Ma	ii viaiiu /	Departme	ill Ul Health	COLICE INTO		gierie		
	•	1 - State Registrar		,		ite of Death			Reg. No. 2	004	1244
Physic /Medi		1. Decedent's Name (First, Middle, L. D. O. U.G. L. A.S.	arms a second	= T	HO MA	45		2. Date of De Month March	Day	2004	3. Time of Death
Exami		4a. Facility Name (If not institution, gi		2.1.1		y, Town, or Location				nty of Death	
		Anchorage No. 5. Social Security Number 6.	Sex J 7. Age	e (In yrs. last t	birthday) If Und	ler 1 Year Il Unde	r 24 H/s.	8. Date of Bir	th	9. Birthpl	ace (State or Foreig
Funeral Director			10 Y M 2□F	61	Yrs. Month	s Days Hours		4ug. 1	9,1942	Mai	ryland
within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Modical Examiner must be notified at	_	10a. State 10b. County			wn or Location					10	Xd. Inside City Limit:
Be-f	ecto		cester	Ber	-1in	Zip Code			10g. Citizen o	of Miles Cours	
ges 1 and 2 should be filed within 72 hours after death with the Marylan tt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23e or 28e-f show or other treumatic event, the Medical Examiner must be nutified at	Funeral Director	100. Street and Number	Aven	u o	101. 2	21811			11	< 1	uy:
death ms 23	nera	100 Grahan 11. Marital Status	12. Was Decedent 8		13. Was Dec	cedent of Hispanic O cecify Cuban, Mexica	rigin? (Spec	ify Yes or No)- 14. R	ace - America	
after or ite	/ Fui	1 Never Married 2 Married	Armed Forces? 1 Yes 2 N If Yes, Give	lo		2 No Specify		roarr, etc.)	Speri	cifv:	
hours ural',	d by	3 ☐ Widowed 4 M Divorced	Year or Dates:	16	a. Decedent's Us	cual Occupation			16h Kind ol	Business/Ind	
in 72 in nat	Completed	15. Decedent's 8 (Specify only highest g	rade completed)		(Give kind of v	work done during mo use retired)	st of workin	g	16b. King of	Dusinessymo	ustry
yiene.	mo	Elementary/Secondary (0-12)	College (1-4or 5	+)	Dishu	vasher			Rest	Laur	ant
be filed Ital Hygi of other	BeC	17. Father's Name (First, Middle, Las	st)					(First, Middle,	, Maiden Sum		
should b nd Ments marked umatice	To I	unkno						VIVOR			
2 sh and is m	1	19a. Informant's Name/Relationship				ess (Street and Numl					,
Health m 27 ther t	-	Douglas Bruce 20a, Method of Disposition	e Thoma	ZUU. Plate	Of Disposition (A	arrie Ur	r 37	ite I	20c. Locatio	n City or To	vn, State
rages nent of int: If its iry or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		1	tery, crematory o		2/2/	104	00.11	63.2	MD
- 문문등 .		21. Signature of Funeral Service Lice		Wila:	22. Name	and Address of Faci	ility , ,	lous b	2 A.	rage	/VID;
Depa Impo eny in		Janelle (7. Denry	7	HeN	and Address of Faci Ry Fune Washing	tow ST	L. Can	ibrida	e. MD	,21613
333		23a. Part Enter the disease, or co	molications that caus	1				-	U		Approximate
			y one cause on each lin	Mhe death. Di ne.	o not enter the m	ode of dying, such	s cardiac or	respiratory a	rrest,		Interval Between
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Attanding Physician: The law requires that the death certificate be executed to death. Cator: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit of page 2.	edical Certification; To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. A SC V Due to (or as a b. RENA Due to (or as a c. RENA Due to (or as a c. PS EU C. Due to (or as a c. PS EU C. Due to (or as a c. PS EU C. Due to (or as a c. Ps EU C.	a consequence a consequence a consequence of pregnancy 2 Fetal death time of death ut not resulting y Year) 28t y Year) 28t of my knowled f examination ated.	onot enter the miles of): PALL and A Sectopic 5 Other of 1 Other	26. Place of at the time, date at on, in my opinion, decays. License number 29c. Licen	t I. ce of Death Nursing Hom No and place, as eath occurre	23e. Did t 1	23d. I	ontribute to the solution of the contribute to the solution of the contribute to the solution of the contribute of the c	Ty Day Year e cause of death? ably 4 © Unknow sy findings availably pletion of cause of 2 No Route Number, ated. the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Reg. No. 200 L Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 24, 2004 4c. Sounty of Death eorge URNER March /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Easton Talbot Manadier Road 6 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 10 M 2 □ F 215-36-046 | Usual Residence of Decedent Yrs. Maryland Director death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No **Funeral Director** Talbot aston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? tems 23a or 48 Road 21601 Manadier 6 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status of Health and Mental Hygiene.
item 27 Ie marked other than "natural", or Item
other traumatic event, It e Modeal Examinar 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 PNo Specify: Specify: Black Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seaford Industry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 1 and 2 should be Bantum ဨ Lowler enora Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7-Manadier Road-Easton MD. 2.
Date 20c. Location Lity or Town, State MD. 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Methed of Disposition Pages 1 ō = 5 1 Burial 2 ☐ Cremation 3 ☐ Removal from State aughter Cemetery permit. Page Department of Important: If any injury or once. 27/04 Easton, Maryland 4 □ Donation 5 □ Other (Specify) 23a. Part. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as Cardiac or respiratory arrest,

Approximate

Immediate Cause (Final Approximate Interval Between Onset and Dear Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due (or as a Examiner 1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last D e to (or a a con equence of): Physician/Medical Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown signed to Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 200 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 200 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home Pesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Medical Certification: To 1 Tes Mo 3 DOA this After thi funeral 27. Manner Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi death. investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Nonth, Day, Year)

Registrar

State

31. Date filed (Month, DMAR) 2 9

9

enmier

2004 Registar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TOWNSEND

			For State Registrar	State of Maryland / [rtment of He tificate of D			giene Reg. No. 20	04	12443
ı	Physici		Decedent's Name (First, Middle, Last) Robert J	Tracy	-	larine v		2. Date of De Month April	ath Day	Year	3. Time of Death 10:45 A ^M
Ç.	/Medi Examir		4a. Fecility Name (If not institution, give s			4b. City, Town, or L	ocation of Death	ADITI	4c. County	of Deeth	10:45 A
			2513 Bollard Rd.			Anna	apolis		Anne	Aru	ndel
	Funeral Director		476-20-0961	M 2□F 7. Age (In yrs. last bir	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 6-3-1	th y, Year) 924		place (State or Foreign ntry) nesota
	and		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Tow	m or Loc	ation				1	10d. Inside City Limits
	Maryli f sho	ō	Maryland Anne Arun			apolis					1 ☐ Yes 2 📆 No
	the 7	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	/hat Cour	ntry?
	th with		992 Riversedge Circ	le		21401			USA		•
ထ	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural; or Itema 23e or 28e-f show matic event, the Medical Exeminer must be notified at	Funeral		Was Decedent Ever in U.S. Armed Forces? XYes 2 □ No If Yes, Give		/as Decedent of His Yes, specify Cuban ☐ Yes 2X No	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		k, White,	
21215-0036	ural',	d by	3 Widowed 4 □ Divorced	Year or Dates: 1943-46					Specify		ite
7	n 72 I	lete	15. Decedent's Educ (Specify only highest grade	ation 16a. completed)	(Give k	ent's Usual Occupat aind of work done du O NOT use retired)	ion ring most of work	ing	16b. Kind of Bu		
7	withii iene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) Vears		lyst			Nation: Agency	al Se	ecurity
	i Hygi other	BeC	17. Father's Name (First, Middle, Last)	years	THIC		18. Mother's Nam	e (First, Middle,		θ)	
lan	Mental Mental arked o	ToB	Cornelius A.	Tracy			N	Mary Man	gan		
Maryland	2 m m	1	19a. Informant's Name/Relationship (Typ	e, Print) 19b	. Mailing	Address (Street an	d Number or Run	al Route Numbe	r, City or Town,	State, Zip	Code)
	s 1 and 2 of Health item 27		Mary K. Stewart/ Da	ughter 96	606	Van Buren					
Baltimore,	S to II		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Re		f Dispos ry, crem	ition (Name of atory or other place)		Date	20c. Location -	City or To	own, State
	t. Partmen		*4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral Septice License	Kala		rematory	4-7-				Maryland
g	permit. Page Department of Important: if any injury or		> World- [Mile	5	29	Name and Address 73 Solomo	ns Islan	d Rd. E	dgewateı		cal Home 21037
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do recause on each line.	not ente	r the mode of dying,	such as cardiac	or respiratory are	rest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Glauden	(gncer				6	Onset and Death
	Examiner		1	Due to (or as a consequence of	of):						/
ş	sat P	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of	of).						
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events								
ĵ	be executed icien and burial-transit		resulting in death) Last	Due to (or as a consequence of	of):						
04/8	cate be executed physicien and the burial-transit	dical	d.								
٥	ertifica ding pl	0	IF FEMALE:	- 11					1		
X Q Q	that the death certifi ed by the attending (detached for use as	cian/M	in the past 12 months?	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death		Ectopic pregnancy			23d. Date Mon		ry Day Year
j.	the de y the ached	Physic	1 Yes 2 No 9 Unknown	9□ Unknown	2 🗀	Other (specify)					
T	The law requires that that the has been signed by to age 2 should be detact	by Pt	Part II. Other significant conditions cont	ributing to death but not resulting in	the und	derlying cause given	in Part I.	23e. Did to	bacco use contri	bute to th	e cause of death?
	w require been sig should b							1,00	es 2 No	3 🗌 Prob	ably 4 Unknown
Records,	law requ as been 2 shouk	Completed						24a. Was a		ere autor	osy findings available
		Com						autops perform 1 Yes	med? de	ath?	npletion of cause of 2 No
VII	Phyaician: this certific	Be (25. Was case referred to medical examiner?			2	26. Place of Death				
5	Phyai this c	L 2	1 1 163 2 140	spital: 1 Inpatient 2 ER/Out		3□ DOA Other:	4 Nursing Ho				TT
	ding Phys	ion:	27. Manner of Death 1. Natural 5 Pending		rime of	28c. Injury a Work? M 1 ☐ Ye		28d. Describe h	ow injury occurre	d	Home
VISION	deatl deatl ctor: y the	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, far	rm stree		s 2 No	28f Location (St	treet and Numbe	r or Que	I Pouto Number
2	al or /	Certification:	4 Homicide determined	building, etc. (Specify)	,	i, izotory, ombo		City or Town	n, State)	or riurar	riodie Number,
	To the Hospital or Attending Physician: Whin 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director.	edical (29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examine	cian: To the best of my knowledge, er: On the basis of examination and and manner stated.	death of	occurred at the time, estigation, in my opin	date and place, a	and due to the caed at the time, d	ause(s) and man ate and place, ar	ner as sta nd due to	ated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier			29c. License n			9d. Date signed		
			V/0000			1000	51301	1	APRIL!	5, 2	2004
			30. Name and address of person who com Kenn Khoff	900 Gestsa (1	12000 S	51301 ute 300	Lyner	olis, MI	214	101
44	Sta Registr		31. Date filed (Month, Day, Year) APR 0 6 2	32. Registrar's Signature	A	food					

			1 - For State Registrar	State of Marylar		nt of Health and te of Death	Mental Hygiene	2001 10111
4	Physici /Medio	cal	1. Decedent's Name (First, Middle, Last, Charles Education) 4a. Fecility Name (If not institution, give	vard 1h	om as	T, Town, or Location of Dea	2. Date of Death Month De 03 28	y O'ear 7.54 PM
	Examir Funeral Director	ier	5. Social Security Number 6. Sec	en Dr. Apt	1. A5 PO	(Omoke er 1 Year If Under 24 Hrs	5. 8. Date of Birth (Month, Day, Year)	Vorcester 9 Birthplace (State or Foreign
	e Maryland 8a-f ahow	ctor	10a. State 10b. County Worces	ter Po	ty, Town or Location			10d. Inside City Limits 1 Der 2 □ No
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avant, the Medical Examinating the notified at	by Funeral Director	10e. Street and Number 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Agned Forces? 1 Decedent Ever in U Agned Forces? 1 Decedent Ever in U 1 Decedent Ever in U 1 Decedent Ever in U	H. A5 2	ip Code J J J J sedent of Hispanic Origin? (: berity Cuban, Mexican, Pue) 2D(No Specify:		14. Race - American Indian, Black, White, etc.
121215-0036	filed within 72 ho Hygiene. ther than "natur. ant, ine Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		M.C.C.	ork done during most of wouse retired)	Se	and of Business/Industry
Maryland	should be fit and Mental H is marked off	To Be	Charles Edward 19a. Informant's Name/Relationship (Ty	and Thomas	19h Mailing Address	18. Mother's Na	Me (First, Middle, Maiden	vis
altimore, Ma	00= 5		20a. Method of Disposition 1 A Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	ON (SISTER) 20b. I	Place of Disposition (Na cemetery, crematory or illoh U.M.	Street P	o como ko	cation - City or Town, Stete
Balti	permit. Pag Department Important: I any injury o		21. Signature of Fune/al Service Licens	ee ul		and Address of Facility B	envie Sm smoke Ci	ith Funcial Home
	Physician /Medical		23a. Part 1. Enter the disease, of complete shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	ications that caused the dealer cause on each line. Due to (or as a consec	tic Smal	de of dying, such as cardia	Cancer	Approximate Interval Between Onset and Death MeMTA
0,	rate be executed with bysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a consec				
09289	death certificate be executed e attending physician and od for use as the burial-transit	Medical	IF FEMALE:	1				
.O. Box	that the death certifica ed by the attending ph detached for use as th	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnative birth 2 ☐ Feta 4 ☐ Pregnant at time of conditions of the second second second second second second second second second second second second second second second second second second sec	al death 3 □Ectopic ;			23d. Date of delivery Month Day Year
ords, P	The law requires that the te has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions con	ntributing to death but not res	sulting in the underlying	cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown
Vital Records,		Completed					24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
. Vit	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	ER/Outpatient 3 □ D	04	ath <i>Check onlone</i> Home 5 X Residence	6 ∏Other (Specify)
ion of	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)		28c. Injury at Work?	28d. Describe how injur	
Division	o it o	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, facto	ry, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)
	Hospi 24 hou Funer fely fill	edical	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my knowner: On the basis of examina	owledge, death occurred ation and/or investigation	dat the time, date and place n, in my opinion, death occ	e, and due to the cause(s) urred at the time, date and	and manner as stated. It place, and due to the cause(s)
	To the Hospital within 24 hours a To the Funeral E completely filled	Med	29b. Signature and title of certifier	and manner stated.	29	c. License number	29d. Dat	te signed (Month, Day, Year)
			Lohen Ta. Ch	intar, MD		0005677	6 3/	31/04
			30. Name and address of person who co	impleted cause of death (Iter	m 23a) (Type, Print)	CARROLL	0 3/ 57 SALIS	BURY, MD 21801
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registra's Signa	ature			

DHMH 17 Rev 1/2001

ORIGINAL

	For State	ate of Maryland / De	epartment of He	ealth and M	ental Hygi	ene200L	121.1.5
	Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of D	peatn		g. No.	3. Time of Death
Physician	William LERO	" Themes			Month	Day Year 25 2004	
/Medical Examiner	4a. Facility Name (If not institution, give stree	7	4b. City, Town, or I	Location of Death	marca	4c. County of Dea	
	PENINSULA REGIONAL	Medieni Cen	TW SAL	ISBUM		HICOM	7100
Funeral	5. Social Security Number 6. Sex	2□ F . 7. Age (In yrs. last birth)	Months Dave	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
Director	211-52-0571 125M Usual Residence of Decedent	31"	3.		02-07	1-50	MD
yland	10a. State 10b. County	10c. City, Town					10d. Inside City Limits
Be-18	MD Somers	ET MAP					1 Yes 2 No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28e-1 show any injury or other traumatic event, the Medical Examiner high motified at once. To Be Completed by Funeral Director	5105 White	Road	10f. Zip Code	238	10	g. Citizen of What Co	ountry?
ms 23	11 Marital Status 12. V	Vas Decedent Ever in U.S.	13. Was Decedent of His	spanic Origin? (Spe	cify Yes or No-	14. Race - Ame	
after or ite	1 Never Married 2 Married 1	Armed Forces? ☐Mes 2 ☐ No I Yes, Give	If Yes, specify Cuban 1 ☐ Yes 2 ☑ No	Specify:	Hican, etc.)	Specify: 2	te, etc.
003(hours a turel', o	3 Widowed 4 Divorced	fear or Dates:				L)	lach
in 72 n naf	15. Decedent's Educatio (Specify only highest grade cor	npleted) (Decedent's Usual Occupat Give kind of work done du ife. DO NOT use retired)	uring most of workin	79	6b. Kind of Business	Vindustry
21215-0(ed within 72 hou gigiene. For then "nature in the Medical E. t, the Medical E.	Elementary/Secondary (0-12)	College (1-4or 5+)	Nachine C) perator		Kubberse	· (D.
ind be file tal Hy d oth d oth event	17. Father's Name (First, Middle, Last)			18. Mother's Name	1.1		
ryla hould d Men marke maric	19a. Informant's Name/Relationship (Type, F		Mailing Address (Street ar	Daisy and Number of Pure		dok City or Town State	Zin Codo)
Ma nd 2 s lith an 27 is r	AntiA L. Thomas	1.13	15 K/6: le's	Road J	lacion.	MD 21	838
or Hear item	20a. Method of Disposition	20b. Place of D	Disposition (Name of crematory or other place)	D	7-7-	0c. Location - City or	Town, State
Page Page ment of ury or	1 █ Surial 2 ☐ Cremation 3 ☐ Remo • 4 ☐ Donation 5 ☐ Other (Specify)	John U	Jesley Cemed	u/s 03-3	51-4	Marion,	MD
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or any injury or other traumatic event, the Medical Examinance.	21. Signature of Funeral Service Licensee		22. Name and Address	of Facility F	uneral H	rome	
	23a. Part1. Enter the disease, or complication	ons that caused the death. Do no	311 0000	J. Chom	cla, Mr	2011	Approximate
Physician	shock, or heart failufe. List only one ca Immediate Cause (Final	use on each line.	ASCUD	,	, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death
/Medical	disease or condition resulting in death)	Due to (or as a consequence of					
Examiner	Sequentially list conditions, b						
led nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
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18760, cate be executed physician and it the burial-transition dical Examilia							
X 68 x 68 ding ph	IF FEMALE:						
Sr. 317-52 cords, P.O. Box 6 wrequires that the death certific been signed by the attending should be detached for use as letted by Physician/Mer	23b. Was decedent pregnant in the past 12 months?	f yes, outcome of pregnancy	3 Ectopic pregnancy			23d. Date of de Month	livery Day Year
O. O. the de the de ched ched nysic		I□Pregnant at time of death P□ Unknown	5 Other (specify)				
Records, P.O The law requires that the law been signed by the page 2 should be detached.	Part II. Other significant conditions contribu	iting to death but not resulting in t	he underlying cause giver	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ords squire en sig build b					1 🗀 Yes	3 2 □ No 3 □ Pi	robably 4 []Unknown
D 22 2					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
fomas, formas, rate and recentificate has be a director, page 2 si					perform 1 Yes 2	ed? death?	2 □ No
of Vital of Vital Physician: Tithis cartificate ral director, pa	25. Was case referred to medical examiner? 1 Des 2 No	tal: 1 ☐ Inpatient 2 ☑ €R/Outp	Othor	26. Place of Death			
The of of of or this control of the of this control of the oral direction; To	27. Manner of Death 28	Ba. Date of Injury 28b. Tin	ne of 28c. Injury		8d. Describe hov	nce 6 Other (Spe w injury occurred	city)
sion auth. or: Aft	2 Accident investigation	(Month, Day Year) Inji		es 2 No			
Division of Division of State	3 Suicide 6 Could not be determined	Be. Place of Injury - At home, fam building, etc. (Specify)	n, street, factory, office	2	8f. Location (Stree City or Town,	eet and Number or Ri State)	ural Route Number,
	29a. Certifier 1 Certifying Physicia	n: To the best of my knowledge,	death occurred at the time	date and place a	nd due to the cau	uso(s) and manner as	stated
LL Le Hospi nn 24 hou he Funei pletely fil	(Check only 2 Medicel Exeminer:	On the basis of examination and/ and manner stated.	or investigation, in my opi	nion, death occurre	d at the time, dat	te and place, and due	to the cause(s)
To th withir To th comp	29b. Signature and title of certifie		29c. License	number	29	d. Date signed (Mont	h, Day, Year)
	Clu Sun	Do.	H50	79497	3	3/27/04	
	30. Name and address of person who comple		ype, Print) E. Ca	rroll (+	Salia	bury mo	21801
State	31. Date filed (Month, Day, Year)		4	-		1,100	
Registrar	MAR 2 9	32. Registrar Signature	& Sparke	•			

				State of Maryland / [•	_	
			1 - For State Registrar	State of Maryland / L	Certificate of			. No. 2004	121.1.6
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of	Death	2. Date of Death	. No. 2 0 (1 L)	3. Time of Death
	Physici	an	D1	thomas Co	ſ		Month	Day Yeer 28 2004	12:45 PM
,	/Medio		4a. Facility Name (If not institution, give st	reet and number)	4b. City. Town, o	r Location of Death	rares .	4c. County of Deeth	70.
•	Examir	er	12714 Old Fort	L // 1	and the same of	shingto.	n	frince 1	serge-
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bit	thday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthp	lece (State or Foreign
	Director		264-04-2264	M 20 F 53	Yrs. Months Days	Hours Min.	Month, Day, Y	950 South	Cardina
			Usual Residence of Decedent				7 /		at the day of the history
	inylan ihow		10a. State 10b. County	10c. City, Tow	. 1 10	1		1	Od. Inside City Limits 1 ☐ TES 2 ☐ No
	Ba-f s	cto	Md. trinee Ge	earges It.	. Washing	1700			
	ith th	Dia	10e. Street and Number	+21	10f. Zip Code	· · · · · · · · · · · · · · · · · · ·	10g	g. Citizen of What Coun	Ary?
	n 72 hours after death with the Maryland "natural", or flema 23a or 28a-f show refeal Examinet must be notified at	Funeral Director	12714 Old For			744	pointy Voc or No	14. Race - Americ	ean Indian
		une	The Marital Otatos	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 ☐ No	13. Was Decedent of H If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Black, White,	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No	Specify:		Specify: B	lack
15-0036	within 72 hours after ene. then "natural", or ite tie Wedical Examina	ed	15. Decedent's Educa		Decedent's Usual Occup	pation	16	6b. Kind of Business/Inc	dustry
5		piet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of work d)			,
212	be filed within 72 hc lal Hygiene. d other than "natur event, the Medical	Completed	12	1/1	tomer Service	Communica	tion free 1	D.C. Gove	rnment
٥	be filed tal Hygi d other	Bec	17. Father's Name (First, Middle, Last)			2001	e (First, Middle, Ma	iden Sumame)	
<u>la</u>		Tof	King Albraham			Lillie		199ers	
Maryland	2 sho and I is ma		19a. Inform s Name/Relationship (Typ	e, Print) 19t	. Mailing Address (Street	and Number or Rur	al Route Number, C	City or Town, State, Zip	Code)
	and tealth m 27		Brian Brooks [JON 1 10	lashing ton.	00	20020		
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	l cometa	f Disposition Name of ry, crematory or other pla		Date 20	c. Location - City or To	1
Ě	Pages ment of i		' 4 ☐ Donation 5 ☐ Other (Specify)	128	14 Memorial to	irk Apri	1 2 2004	Landover	Md.
3a1	permit. Pag Department Importent: any injury c		21. Signature of Funeral Service License	The The The The The The The The The The	22. Name and Addre	ss of Facility Fur	neval Ser	rvice	in the contract
	<u>~</u> 0 ≥ ≈ 0		ager 6.1	Annama 101	1813 Potoma	c Ave. St	E Washi	naton OC	
<u>)</u>			23a. Part 1. Enter the Asease, or complic shock, or heart failure. List only one	e cause on each line.	A STATE OF THE PARTY OF THE PAR			L-3	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	MyorARDI		ARCTIO.	N		
	/Medical Examiner		103diaig in county	Due to (or as a consequence	•	~ 0.0	P*		
Ų.		<u>_</u>	Sequentially list conditions, b.	Due to (or as a consequence		21Q 2	E 147 C		
	ted nsit	Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury	ATHEROSOLE	KOTIC CA	Dinua	0.01.02	DISEASE	
_^	ai-tra	xai	that initiated events c. resulting in death) Last	Due to (or as a consequence		- 27 6 4111	00001400	D. D. C.	
760	that the death certificate be executed ed by the attending physician and detached for use as the buriat-transif	call	d						
89	ificati g phy as the								
Box	andin use a	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23	Bc. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	n 3 □Ectopic pregnanc	v.		23d. Date of delive	•
m	death e atte	icia	in the past 12 months?	4 Pregnant at time of death	5 Other (specify)	y 		Month	Day Year
Р. О.	t the by th tache	hys	9 Unknown	9□ Unknown			-		
s,	signed I	by F	Part If. Other significant conditions cont	tributing to death but not resulting i	n the underlying cause giv	ven in Part I.		cco use contribute to th	
<u>rd</u>	w require been si should t	ed					1 ∐ Yes	2⊠No 3∏Prob	ably 4 Unknown
200	aw re as be 2 sh	plet					24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
ž	The iste his	Completed					performe 1 ☐ Yes 2 €	ed? death?	25 No
ţ	ian: rtifica stor, p	Be C	25. Was case referred to medical			26. Place of Deat	th (Check only one)		
>	nysic nis ce direc	2	examiner? 1 ☐ Yes 2 ☐ No	ospitaf: 1 Inpatient 2 ER/O	utpatient 3 DOA Ott	ner: 4 🗆 Nursing Ho	ome 5 🔀 Residenc	ce 6 □Other (Specif)	y)
Division of Vital Records,	ng Pt fter th		27. Manner of Death 1 Natural 5 □ Pending		Time of 28c. Inju-	ry at rk?	28d. Describe how	injury occurred	
0	endii eath. or: A the fu	Certification:	2 Accident investigation		M 1 🗆	Yes 2□No			
Ž	d or Att	Ę	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	I Route Number,
	ospitel o hours at unerei D ly filled ir								
	Hosp 4 hos Fune Fune	ical	(Check only 2 Madical Exemin	ician: To the best of my knowledger: On the basis of examination are					
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29b. Signature and title of certifier	and manner stated.	29c. Licens	se number	290	I. Date signed (Month,	Day, Year)
)	F 3 F 8		1	He	03	132		3-31-04	·
0	(=)		20 Name and address of account of	moleted cause of death (to one)	Type Print 1170	110000	ton Rosa	512.70	309
_	(8)		30. Name and address of person who con Dr. Victor F 31. Date filed (Month, Day, Year) APR 0 2 2004	Texici i	(iypo, rilli) ///c/	Vacings	for Mr	in alland	20044
	St	ate	31. Date filed (Month, Day, Year)	3 Registrar's Signature	11:0	v a su ing	ion, ila	giana	~0,/-/-
16-	Regist		NDD 0 2 2004	Kee H	Rocall 1				

			1 - For State Registrar	State of Marylar	•	artment of He tificate of D			Reg. No. 2U	
-	Physici /Medic	7	1. Decedent's Name (First, Middle, Last Russell	Taylor	-	4.00		March March	31 200	
Å.	Examin	er	4a. Facility Name (If not institution, give 5113 Due1 Place	street and number)		4b. City. Town, or L Capital	ocation of Death . Heights		4c. County o	ce George's
	Funeral Director		5. Social Security Number 6. Se 228-44-7257	x 7. Age (In yrs	last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day July 18		9. Birthplace (State or Foreign Country) Virginia
	D	tor	Usual Residence of Decedent	-	ity, Town or Lo	cation ital Heigh	ıts			10d. Inside City Limits 1√√√√Yes 2 □ No
	h with the	ai Director	10e. Street and Number 5113 Duel Place		-	10f. Zip Code 20743			10g. Citizen of Wh	•
036	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show striputy or other traumatic event, the Medical Examitter must be traitified at Once.	by Funerai	11. Marital Status 1 Never Married 2 🔀 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of Hisp f Yes, specify Cuban, I ☐ Yes 2⁄√2 No	panic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. Black
21215-0036	within 72 ho iene. than "natur. the Medical i	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 7 th	(cation (e completed) College (1-4or 5+)	(Give	dent's Usual Occupati kind of work done du DO NOT use retired)	on ring most of work	king	16b. Kind of Bus	
Maryland 2	uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, Last) Willis Taylo	r		1		e (First, Middle, ynne Tay	Maiden Sumame 1or)
	and 2 sho laith and P 27 ie ma er trauma	•	19a. Informant's Name/Relationship (T) Hilda Taylor/Wif			g Address (Street an Duel Plac				tate, Zip Code) Land 20743
altimore,	Pages 1		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ ↑ 4 □ Donation 5 □ Other (Specify,	Removal from State		sition (Name of natory or other place) emetery	4/3/2	Date 2004		ity or Town, State Hen Virginia
Balt	permit. Departr Import. eny inji		21. Signature of Funeral Service Licens D. March			. Na <i>m</i> e and Address 474 Landov	J.			eral Home and 20785
) 	Physician /Medical Examiner	nlner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	lications that caused the deal ne cause on each line. Prostate Due to (or as a consection) Due to (or as a consection)	Cance of):		such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
68760,	ficate be executed physicien and s the burial-transit	edical Examiner	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
.O. Box (The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Monti	
rds, P	quires that n signed b uld be deta		Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause given	in Part I.		obacco use contrib es 2 No 3	oute to the cause of death?
Division of Vital Records, P.		Completed			·		· · · · · · · · · · · · · · · · · · ·	24a. Was autop perfor 1 Yes	sy pri rmed? de	ere autopsy findings available or to completion of cause of ath? Yes 2X No
Vita	ysician: Th is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatien	Other	26. Place of Deat		ne) lence 6 □Other	(Specific)
ion of	ding Ph n. After th funeral		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?			ow injury occurred	
Divis	를 들는 를	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str ify)	eet, factory, office		28f. Location (S City or Ton	Street and Number m, State)	or Rural Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier 1	rsician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, death ation and/or inv	n occurred at the time, vestigation, in my opin	, date and place, nion, death occur	and due to the or red at the time, or	cause(s) and man date and place, an	ner as stated. Id due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and thile of certifier	Day		29c. License r			29d. Date signed ((Month, Day, Year)
2	(20)		30. Name and address of person who of David Perry M.	- /1		Print)		ם חר פת		
, a	Sta Regist		31. Date filed (Month, Day, Year) APR 0 2 2004	32. Registrar's Sign	ature		JILLIGEOL	1, 10 20	010	***************************************

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

2107		Please	Type or Print						
		For	State of Ma	ryland / De	epartment of I	Health and N	lental Hygi	ene UUL	12449
		1 - State Registrar			Certificate of	Death		3. No.	16777
Physicia		Decedent's Name (First, Middle, Lo Carlos	D. Thomas				2. Date of Death Month March 2	Day Year	3. Time of Death 1046 a ^M
/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)	-	4b. City, Town,	or Location of Death		4c. County of Death	
		Prince George	s Hospital	Center	Chev	verly		Prince Ge	orges
Funeral Director			Sex 7. Age 1⊠M 2□F	(In yrs. last birthe	Months Days		8. Date of Birth (Month, Day, 1) June 20,	(ear) 9. Birth Cou	place (State or Foreign ntry) yland
p .		Usual Residence of Decedent 10a, State 10b, County		10a City Taylor					
anyla shov	ž			10c. City, Town					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
28a-f	ecto	Maryland Prince G	George	Upper M			140		
ours after death with the Manylan al', or Itema 23a or 28a-1 show Examiner rouat be notified at	Funeral Director	10007 Graystone	Drive		10f. Zip Code	772		g. Citizen of What Cou nited STat	•
leath	era	11. Marital Status	12. Was Decedent Ev	ver in U.S.	13. Was Decedent of H			14. Race - Ameri	
r iter	핊	1- Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖾 No		If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Black, White	
ours a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2又 No	Specify:		Specify: Bla	ack
filed within 72 hours after death with the Maryland tkygiene. uther then "natural", or Itema 23a or 28a-f show nnt, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. D	ecedent's Usual Occup	pation	ing 16	6b. Kind of Business/Ir	dustry
nthin ne.	ď	Elementary/Secondary (0-12)	College (1-4or 5+) '//	Give kind of work done fe. DO NOT use retire	d)	9		
led w tygier her ti	S	8th	41		Student	40.11.45(11.55	(F)	School School	
ntal H	Be	17. Father's Name (First, Middle, Las. Calvin Thomas	0				e (First, Middle, Ma	niden Sumame)	
d Mer narke	၉		Time Dian	- (10)		L	Pinkley		
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa QRGS.		19a. Informant's Name/Relationship Eligha Thomas/Gra	-					City or Town, State, Zip	
1 and Healt em 2		20a. Method of Disposition	ndrather					rlboro, MD	
ages nt of r: If it		1 ⊠ Burial 2 ☐ Cremation 3		l _	isposition (Name of crematory or other place				
artme artme ortan injury		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		Kesurre	ection Cem. 22. Name and Addre			Clinton, M	υ
Depa Impo any ir		Mus &	DilolV		EE. Hallio and Hadio		pe Funer 38 Marlb prestvill	oro Pike	
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused th	ne death. Do not	enter the mode of dyir	ng, such as cardiac	restvill or respiratory arres	e, MD. 20	747 Approximate
Physician		Immediate Cause (Final	00 11			4			Interval Between Onset and Death
/Medical		disease or condition resulting in death)	a. (Y)u(+ip)		ies with c	umplication	15		
Examiner	1	1		7.00					
	ner	Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	sunsuquence of)					
nd	Examiner	Cause (Disease or injury that initiated events	c						
		resulting in death) Last	Due to (or as a	consequence of)					
icate b physic s the b	dical		_ d						
eath certific attending pi	Physician/Medic	IF FEMALE:	23c. If yes, outcome of	Drogococc					
atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at tir	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	1		23d. Date of delive Month	ery Day Year
by the tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	ne or dealir	5 Other (specily)				
igned by	Y P	Part II. Dther significant conditions	contributing to death but	not resulting in th	e underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
law requires that the death certificate as been signed by the attending phy; . 2 should be detached for use as the	d by						1 🗆 Yes	2 No 3 □ Prob	ably 4 Unknown
s been should	Completed						24a. Was an	24b. Were auto	psy findings available
The age	E						autopsy	d? prior to co	npletion of cause of
ician: certifica ector, p	0	25. Was case referred to medical				26 Place of Death	15 Yes 2	No SKYes	2 No
99 (6 =	0	axaminar? 1 🏲 Yes 2 🗌 No	Hospital: 1X Inpatient	2 ER/Outpa	trent 3 DOA Oth	0.00	-	e 6 □Other (Specifi	4
ding Ph h. After th funeral	ü	27. Manner of Death	28a. Date of Injury (Month, Day Y	(ear) 28b. Tim	e of 28c. Injur	y at	28d. Describe how		,
Mtendir death. ctor: Af y the fur	atio	1 Natural 5 Pending 2 Accident investigatio	3/20/64			Yes 2X No	assenses of	auto involved	incollision
or Attending Ifter death. Director: After in by the fune	탩	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	- At home, farm	street, factory, office		28f. Location (Stree	t and Number or Dura	I Pouta Numbos
italo rsaft raiDi	Certification:		310	+		1	Uprax well	itate) Old maribo	10 HIKE
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exer	nysician: To the best of on miner: On the basis of ex and manner state	camination and/o	eath occurred at the tin r investigation, in my o	ne, date and place, pinion, death occurr	and thus to the sour	(a/a) and manner as at	ated. the cause(s)
within 2 To the comple	Me	29b. Signature and title of certifier	, NI		29c. Licens		29d.	Date signed (Month,	Day, Year)
	-	• 4 1	N. It		0	CME	M	larch 27 20	04
(5)		30. Name and address of person who	() 40	th (Item 23a) (Ty	pe, Print)				
		JACK MI	Titus, MiD.		111 Pe	nn Street	, Raltimo	re, Maryla	
Stat Registra		31. Date filed (Month, Day, Year) MAR 3 0 2004	82. Registrar's	Signature	7				
ricgistia		דטטים ע נו קואויון	politice.	5 AM	42/				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - Stote	State of Ma	ryland / Dep	artment e ertificate				-	001	10150
			Registrar 1. Decedent's Name (First, Middle, Las	st)		Tuncale	UI Deal	11	2. Date of Deat	g. No.2	<u>UU4</u>	3. Time of Death
4	Physic /Medi		WILLIAM RUSS	ELL THIC	KSTUN JR				Month MARCH	Day 31	2004	10:12 A M
•	Exami		4a. Facility Name (If not institution, give	street and number)			wn, or Locatio	n of Death	111111011		inty of Deeth	
			SHADY GROVE ADVI				CKVILLE			MOI	NTGOME	RY
×	Funeral Director		5. Social Security Number 6. S 578 22 8841	ex 7. Age M 2 □ F	(In yrs. last birthday 81 Yrs.		Year If Und	er 24 Hrs. s Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Country)			place (State or Foreign intry)
			Usual Residence of Decedent		01				0ct. 1	4 1922 Washington,D.C		
	rylan		10a. State 10b. County		10c. City, Town or L							10d. Inside City Limits
	8a-f.s	Director		gomery	Gaith	ersbur	g					1 Yes 2 □ No
	ier death with the Maryland Items 23s or 28s-1 show Int mist ve notified at	훕	10e. Street and Number		"017	10f. Zip Co			10	g. Citizen	of What Cou	intry?
	leath	Funeral	419 Russell Aver	nue, Apt.		Was Docodon	20877	Origin 2 / Co.	neite Van an Na		ted St	
9	after o		1 ☐ Never Married 2 🗷 Married	Armed Forces? 1				an, Puerto	ecify Yes or No- Rican, etc.)		Black, White	
93	hours after tural', or Ite	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	MMII	1 ☐ Yes 2 🗷	No Specif	fy:		Spe	cify: W	Mhite
5-(n natu	Completed	15. Decedent's Ed (Specify only highest gra-	ucation de <i>completed)</i>	(Give	dent's Usual O	tone during mo	ost of worki	ng	6b. Kind of	Business/Ir	ndustry
12	the ene	dmo	Elementary/Secondary (0-12)	College (1-4or 5+	+)	hematic	· ·			C- 11		
d	事事	Be Co	17. Father's Name (First, Middle, Last)	0	ria t	TIEIIIA E I		her's Name	(First, Middle, N	Coll laiden Sum		
lan		To B	William Russe	ell Thio	ckstun			belle		_	vers	
Maryland 21215-0036	2 sho and h is ma		19a. Informant's Name/Relationship (7		19b. Mail	ng Address (St	treet and Num.	ber or Rura	l Route Number,	City or Tow	vn, State, Zij	o Code)
	i. Pages 1 and 2 should b itment of Health and Menti rtent: if Item 27 is marked hjury or other traumatic e		Mary E. Thickstu	in / Wife	The same of the sa	The state of the s			, Gaithe			
Baltimore,	or or or		20a. Method of Disposition 13€ Burial 2 □ Cremation 3 □		1	matory or other	r place)				n - City or T	
Ħ	permit. Pa Departmen Important: eny injury once.		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen: 		Laytonsv			4/3/			svill	e, Md.
ä	permit. Departimportimport eny inj		1 muriel	W. Ba	rh.	Muriel P 0	H. Ba	rber	Funeral	Home	Ma	20882
	¥		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused t	he death. Do not en		dying, such a	s cardiac o	Laytonsv r respiratory arres	111 e, st,	IVIQ .	Approximate
	Physician		Immediate Cause (Final disease or condition		PERFORATI	ON						Interval Between Onset and Death HOURS
	/Medical Examiner		resulting in death)		consequence of):	011						1100113
		6	Sequentially list conditions,		ATORY FAI consequence of):	LURE						IMMEDIATE
	uted d ansit	Examine	Signostian, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		BLEEDING							HOURS
o,	an an	Exa	resulting in death) Last		consequence of):							0.000.3
8760,	death certificate be executed e attending physician and d for use as the burial-transit	dical		d								80 - 3
9		/Med	IF FEMALE:	20- 11		_						Months of the Control
Box	attending p	clan	in the past 12 months?	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti	Fetal death 3	Ectopic pregna					ate of delive	Day Year
P.O.	that the de led by the a detached t	hysk	1 Yes 2 No 9 Unknown	9☐ Unknown	ine or death 35	J Other (specπ)	<i>"</i>		P-1			,
	The law requires that the tee has been signed by the bage 2 should be detached.	Completed by Physician/Me	Part II. Other significant conditions co			nderlying cause	given in Part	l.	23e. Did toba	cco use cor	ntribute to th	ne cause of death?
Vital Records,	w require been sig	led l	ADVANCED PARK	INSON'S DI	SEASE				1 ☐ Yes	2 🗆 No	3 🔲 Prob	ably 4 Unknown
ecc	law r las be	nple	PROSTATE CANC	ER					24a. Was an autopsy	24b	. Were auto	psy findings available
al R	ician: The la certificate has ector, page 2								performe	No No	death?	npletion of cause of 2 No
	tending Physician: leath. tor: After this certific the funeral director,	œ	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	tospital:			Ost		(Check only one)			
0	g Phy er this	n: To	27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day)	2 ER/Outpatier 28b. Time of	28c. l	niurv at		e 5 🗌 Residence 8d. Describe how			"
ion	ath. rr: Aft	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day)	rear) Injury	1	Work? 1 □ Yes 2 □					
Division of	or Atter de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	/ - At home, farm, str (Specify)	eet, factory, offi	ice	28	Bf. Location (Stre- City or Town,	et and Num	ber or Rura	Route Number,
0	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer			4						,		
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exami one)	sician: To the best of e ner: On the basis of e apd manner state	kammation and/or in	occurred at the estigation, in m	e time, date ar ny opinion, dea	nd place, ar ath occurred	nd due to the caus d at the time, date	se(s) and m and place,	anner as st	ated. the cause(s)
	ro the	₩ W	29b. Signature and title of certifier	and marmer state			ense number				ed (Month, L	
	1/		· ole			0	60541	39				1, 2004
(1	0)		30. Name and address of person who co	mpleted cause of dea	th (Item 23a) (Type,	Print)						/
7			DUC T. LE, M.D.		DICAL CENT	TER DRI	VE, RO	OCKVIL	LE, MD.	2085	50	
	Stat Registra	-	31. Date filed (Month, Day, Year) APR 0 2 206	32. Registrar's		Som	1/2/					

			1 - For State Registrar	State of Marylar		artment of rtificate of			iene 9. No 2004	12451
AT SE	Physic /Medi		1. Decedent's Name (First, Middle, Last John Frederick	Thies, Sr.				2. Date of Dear Month March		3. Time of Death
J.	Exami		4a. Facility Name (If not institution, give	Orive		C	or Location of Death	rk	4c. County of Dea	ith
	Funeral Director		5. Social Security Number 718-14-9770 6. Se Usual Residence of Decedent	DM 2□F	91 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Aug. 18	Year) 9. Bi	thplace (State or Foreign ountry) nsylvania
	ith the Marylan or 28a-f show	ector	Maryland Prince C		lege P	ark				10d. Inside City Limits 1 Yes 2 No
	ath with t	Funeral Director	9110 Autoville Dr	rive		10f. Zip Code 20740		1	og. Citizen of What C United Sta	•
9036	be filed within 72 hours after death with the Maryland nat Hygiene. Id other than "natural", or Itams 23a or 28a-f show event. I'm Medical Examiner must be revitled at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 □XYes 2 □ No If Yes, Give Year or Dates: 1931–1		Was Decedent of f Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: W	erican Indian, te, etc. hite
Maryland 21215-0036	- 10	Completed	15. Decedent's Edu (Specify only highest grad		16a. Deced (Give life. 1 Brake		pation during most of work ad)	ing	16b. Kind of Business Washington Terminal (n Railroad
yland	e should be filed within and Mental Hygiene. Is marked other than aumatic event, I.a.M.	To Be (17. Father's Name (First, Middle, Last) Michael	Thies			18. Mother's Nam Katherir	na	Kartman	
), Mar	and 2 seath ar		19a. Informant's Name/Relationship (Ty Evelyn P. Thies –	wife	9110	Autovill	le Drive (a <i>l Route Number,</i> College F	City or Town, State, . Park, Mary.	Zip Code) land 20740
Baltimore,	Pages ment of ant: If it		20a. Method of Disposition 1 Strial 2 □ Cremation 3 □ F 1 4 □ Donation 5 □ Other (Specify)	For	lace of Dispo emetery, cren rt Linc	sition (Name of natory or other pla coln Ceme	etery 4/1/		oc. Location - City or Brentwood,	
Bal	permit. Departr Importa any inji		21. Signature of Funeral Service License Downland 19	ogward	4	100 LOMOR	er witt Ko	oad Belts	Home, P.	A. ryland 20705
	Physician /Medical Examiner		23a. Part1. Enter the disease, of complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Metastatic I Due to (or as a consequ	n. Do not ente Disease	er the mode of dyli	ng, such as cardiac o	or respiratory arre	st,	Approximate Interval Between Onset and Death 2 months
8760,	death certificate be executed eatlending physician and d for use as the burial-transit	lical Examiner	d any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to for a consequence to for a co						
		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	<u> </u>		23d. Date of deli	very Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions con	tributing to death but not resu	llting in the un	derlying cause giv	en in Part I.		cco use contribute to	the cause of death?
m.	The ate h page	e Completed	25. Was case referred to medical				26 Place of Death	24a. Was an autopsy performe	prior to death?	opsy findings available ompletion of cause of
>	Physician: rthis certific ral director,	ToB	examiner? 1 Yes 2 No	ospital:	ER/Outpatient	3□ DOA Oth	26. Place of Death er: 4 Nursing Hon		ce 6 Other (Spec	(6 ₁)
sion o	After fune	ertification;	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	y at 2	8d. Describe how	injury occurred	,,,,
DIV	orfel or Attendurs after death	OF	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)				City or Town,	•	
	lo the Hospitel within 24 hours a Yo the Funerel Completely filled	Medical	one)	ician: To the best of my know er: On the basis of examinati and manner stated.	viedge, death on and/or inve	occurred at the timestigation, in my op	ne, date and place, a pinion, death occurre	nd due to the cau ad at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
	on To on		29b. Signature and title of certifier	200	Sig	1	number	290	Date signed (Month) March 29,	
	ų.		30. Name and address of person who cor Dpinder Singh, M.	.D. 14330 Gall	ant Fo	x Lane,	#124 Bowie	e, Maryla	and 20715	
	Sta Registra	.c	31. Date filed (Month; Day, Year)	32. Registrar's Signatu	ire &	Sparks				

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 Amend Items 23b, c, PtII, 25, 27, 28 per ME 6833 07/20/04dhb 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** n pman 21407 March ena 2004 /Medical 4a Fecility Neme (If not institution, give street and nu 4b. City, Town, or Location of Death 4c. County of Deet Examiner rove Rockville Montgomery Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2X)F Days Hours Yrs. Director 172-24-6187 July 26, 1931 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show of Heelth and Martel Hygiene.
Item 27 is marked other than "natural", or itema 23a or 23a-f shoother trsumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Maryland Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19310 Club House Road 20886 United States 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours effer to Depertment of Heelth and Mentel Hygiene. Important: If item 27 is marked any injury or care. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 27 No Specify: White Be Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Louis Pasquale Lucy Tullio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10907 Devin Place, Kensington, MD 20895 Robin Tobman Lubin/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Montgomery Crematorium 28, 2004 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Funeral Service Licensee M01346 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) MEDICAL EXAMINER Box 68760. CERTIFICATION APPROV Due to (or as a consequence of) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Junknown Hypertensive Cardiovascular Disease, Atrial δ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? Fibrillation 1 Yes 2 No 1 ☐ Yes 2 X No : After this certifice e funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes ZE No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural s efter deeth.

I Director: Aft
d in by the fur Unknown M 1 ☐ Yes 2X No Subject fell 03/14/2004 **XX**Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number. City or Town, State Montgomery Village, 19310 Club House Road, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Residence To the Hospital within 24 hours e To the Funeral C completely filled Hospital edicai 1 🔣 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner es stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2004 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suhair Abulfarag, M.D. 15215 Shady Grove Road Suite 100, Rockville, MD 20850 Sunali Application of the Sunali Application 32. Registrar's Signeture State Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			•	Certificate of	Death	Reg. i	2004	12453
	Physician	1. Decedent's Name (First, Middle, Last)			2.	Dete of Deeth Month	Day Year	3. Time of Death
	/Medical	Stuart Blair Tor	rence			March 29	, 2004	10:05 pm
	Examiner	4e Fecility Name (If not institution, give street en	d number)		4b. City, Town, or Locati	ion of Deeth	c. County of Death	
		Millenium Health and			Ellicott		Howard	
н	Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. lest bi	rthday) If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Dey, Yea	9. Birthpl Count	ace (Stete or Foreign
	Director	Usual Residence of Decedent	89	7.0.	Fe	eb. 9, 19	915 Virg	inia
	pue & m	10a. State 10b. County	10c. City, Tow	n or Location			10	d. Inside City Limits
	dery Service	Morrison d	77.1	14				1 ☐ Yes 2 ☑ No
	the county	Maryland Howard 10e. Street and Number	E1.	licott City		10a. C	Citizen of What Count	rv?
	with a second	10352 Kingsbridge Ro	o d	2104	4.2		TICA	,
	ifter death with the Mei r Items 23e or 28e-f sinner must be nortified Funeral Director	11. Marital Status 12. Was	Decedent Ever in U.S.		+ ∠ lispanic Origin? (Specify an, Mexican, Puerto Ric	Yes or No-	USA 14. Race - America	
0	Fu Fig.	1 ☐ Never Married 2 ☐ Married 1 🖾 1	ed Forces? Yes 2 □ No			an, etc.)	Black, White, e	
8	al', o	3 ☑ Widowed 4 ☐ Divorced Year	s, Give or Detes: WW I I	1 ☐ Yes 2 🛣 No	Specify:		Specify: Whit	e
5-0	led within 72 hours efter deeth with the Meryland Ygjene. Ner than "natural", or items 23e or 28e-f show it, the Medical Examiner must be norified at Completed by Funeral Director	15. Decedent's Education (Specify only highest grade comple	ted)	Decedent's Usual Occup (Give kind of work done		16b.	Kind of Business/Ind	ustry
2	within ene.		ge (1-4or 5+)	life. DO NOT use retired	d)			
7		12		Inspector			Vater Comp	any
P	是工士艺 4	17. Fether's Neme (First, Middle, Lest)			18. Mother's Name (Fi	irst, Middle, Maide	en Sumame)	
y a		Calvin Dinwiddie To				Cheatham		
Jar	2 9 2 2	19a. Informant's Name/Relationship (Type, Print,		o. Mailing Address (Street				•
0	Heelth Heelth Hem 27 I	Marcia W. Johnson/ Day		0352 Kingsbr Disposition (Neme of				
Baltimore, Maryland 21215-0020	5 = 5	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal f	rom State	ry, cremetory or other place oncord Presb	Apr	il 1,	Location - City or Tov	
ţ	Lant: Po	4 □ Donation 5 □ Other (Specify)	C	hurch Cemete	ry	004 60	ncord, Vi	rginia
3a	emil Seper ny in	21. Signature of Funeral Service Licensee	- 1	Francis J.	ss of Facility Collins F	uneral H	lome Inc.	
	00240	Anne Mariero	CINCI	500 Univer	sity Blvd.	W.,Silve	r Spring,	MD 20901
		23a. Part1. Enter the disease, or complications t shock, or heart failure. List only one cause	hat caused the death. Do on each line.	not enter the mode of dyin	ng, such as cardiac or re	spiratory errest,		Approximate Interval Between
>	Physician	(/3 5 10 10 FT 7	11	00- 6	0 0 0		Onset and Death
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	ONGEST	100 1)8	HH H	HLURE	1	
			Due to (or es a	consequence of):			l I	
	executed in end inel-trensit	b						
	the deeth certificate be executed by the ettending physicien and sched for use as the burdel-trensit hysician/Medical Examir	Sequentially list conditions, if any, leading to immediate	Due to (or as e	consequence of):			İ	
68760,	sicie s buri	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or on a	consequence of:				
68	entificate be ding physicia se es the bu	resulting in death) Last	Due to (or es a	consequence of):]	
×	nding use a	d						
Bo	et the deeth ce d by the ettendi eteched for us: Physician/	Part II. Other significant conditions contributing	to death but not resulting i	n the underlying cause giv	en in Part I	23h Did tobaco	o use contribute to	the cause of death?
Ö	thet the de ed by the e deteched i		To do La Francisco Contraction of the Contraction o		J			ably 4 Denknown
ď.	£ 90 >							
Records,	w requires to been signs should be leted by					24a. Wes en aut		e autopsy findings ilable prior to
ပ္သ	lew requires been a 2 should npieted					periorneur	com	pletion of cause eath?
æ	6 4 8 9 P					1 Yes	2.710 1.	Yes 2ENo
Vital	delan: Tector, prector, p. Be C	25. Was case referred to medical			26. Place of Death (C		(
>	5 0 E	examiner? 1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Ou	utpatient 3 DOA Oth	er: Nursing Home	5 Residence	6 □Other (Specify)	
n of	og Ph ter th nerel	27. Menor of Deeth 28a. □		Time of 28c. Injury	y at 28d. k?	. Describe how inj	ury occurred	
Ö	Attending or deeth. Sctor: After by the fune fune fification	2 ☐ Accident investigation			Yes 2 □ No			
Division	tal or Attending P rs efter deeth. al Director: After t ed in by the funer: Certification:	3 Suicide 6 Could not be determined 28e. F	Place of Injury - At home, fa building, etc. (Specify)	ırm, street, factory, office	28f.	Location (Street a City or Town, Sta	and Number or Rural te)	Route Number,
۵	ral D							
	he Hospital or Attending 24 hours efter death he Funeral Director: A pletely filled in by the fedical Certificati	(Check only 2 Medical Examiner: On the	the best of my knowledge he basis of examination en	e, deeth occurred at the tin d/or investigation, in my o	ne, date and place, and pinion, death occurred e	due to the cause(It the time, date a	s) and manner as sta nd place, and due to	ted. he cause(s)
	To the Hospital or Attending F within 24 hours effer death. To the Funeral Director. After completely filled in by the funer completely filled in by the funer Medical Certification:	29b. Signature and title of certifier	manner steted.	29c. Licens	e number	29d. D	ate signed (Month, D	ey, Yeer)
	1 J.1	Jasuon Va	lehan	18	28595	3	130100	,
	641	30 Name end address of person who completed	cause of death (Item 22a)	(Type Print)	4 4		1 10 1	
		JASNEEM CAKE		220 PAR	CK HEIG	THIS H	WE BA	70 MI)
	State Registrar	31. Date filed (Month, Day, Yeer) MAR 3 1 2004	32. Registrer's Signature	& Sporks				المرابح

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2:12 P M Odell Tilghman Clayton April 2004 /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Waldorf Health Care Center Charles Waldorf If Under 1 Year | If Under 24 Hrs. Months Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Director 237 36 3384 74 Jan 9, 1930 North Carolina Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow be notified at 1 Tes 2 No Directo Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 20602 4140 Old Washington Road or Items 23a event, the Medical Examiner haut United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Pygione. ant if Item 27 is marked other than "natural; or Ite ury or other thaumatic event, Item Mudical Estimiter ury or other traumatic event, Item Mudical Estimite □Yes 2□No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify: þ White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Car Dealer Business Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rodger O. Tilghman ပ္ Doris L. Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dori A. Delph (Daughter) 10616 Ashford Cir. Waldorf, Maryland 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) April 8, 2004 20c. Location - City or Town, Stete permit. Pages 1 Department of H Important: If Ite eny Injury or ot once. 4 □ Donation 5 □ Other (Specify) Suitland, Maryland Washington National Cemetery 21. Signature of Fundral Service License 22. Name and Address of Facility Lee Funeral Home , Inc 6633 01d Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Chronic Renal Failure Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pheumonia Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospitel or Attending Physician: The law requires that the death certificate be executed Exami Cerebro Vascular Accident burial-tran and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical Peripheral Vascular Disease as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) by the a ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 1 🗌 Yes 2 No 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an page 2 has autopsy performed? certificate 1 Yes 2 X X10 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Surviving Home 5 | Residence 6 | Other (Specify) Hospital: ů 1 🗌 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1XXNatural To the nucerus after death.

To the Funeral Director: Aft 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Medical ţ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D44436 April 5, 2004 no completed cause of death (Item 23a) (Type, Print) Shrinkumar Patel, MD 102 Paul Mellow Court, Waldorf, Maryland 20602 31. Date filed (Month, Day, Year) State Registrar APR 0 9 2004

			State of M	laryland /	Departmen Certifica			nd Mental Hy		004	12455
	Physician /Medical	1. Decedent's Name (First, Middle	_	119	Vando	ook		2. Date of De Month March	eth Dey	Year	3. Time of Death
	Examiner	4a Fecility Name (If not institution	-					or Location of Deet	h 4c. Count	y of Deeth	
	Funeral Director	5. Social Security Number 228–28–1853	6. Sex 7. A 1 M 2	ige (In yrs. lest i	birthday) If Unde Months		If Under 24 Hours	Hrs. 8. Date of Bin Min. (Month, De March	ay, Yeer)		place (State or Foreign orry) Cginia
Marylend	art show	Usuel Residence of Decedent 10a. Stete 10b. County Maryland Carro	11	10c. City, To	own or Location Sburg					1	0d. Inside City Limits 1 ☐ Yes 2€ No
th with the	items 23a or 28a-f show ther must be notified at uneral Director	10e. Street end Number 1909 Shetland R	id.		10f. Zij	2104	8		10g. Citizen of		itry?
5-0020 72 hours after death with the Marylend	el', or items 23 Examiner must by Funeral	11. Maritel Status 1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces ed 1 Yes 2 N If Yes, Give Year or Dates:	? No	13. Was Dece If Yes, spe		panic Origin Mexican, P Specify:	? (Specify Yes or No uerto Rican, etc.)	14. Rae Bla	ce - Americ ck, White, y: Whi	etc.
21215-0020 d within 72 hours af	then then	15. Decedent (Specify only highes Elementery/Secondary (0-12)			Decedent's Usu (Give kind of wo life. DO NOT u	ork done du se retired)	ion ring most of	working	16b. Kind of B		
Maryland 7	Mantal Hygicarked other aftic event, to To Be Co	17. Fether's Neme (First, Middle, L William Welton	Burrell			1	Lilly	Name (First, Middle 7 Mae Davi	Maiden Surnar S		
e, Mar and 2 sh	ealth and m 27 is m her traum	19a. Informent's Name/Relationsh Allyson Taylor/		7	614 Knig	htshay		r Rural Route Numb , Manassa			Code)
E &	Department of H Important: If Ites any Injury or ot once.	20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	3 ☑Removal from State ecify)	ceme	of Disposition (Natery, crematory or days) and Buria	other place) 1 Parl	ζ.		20c. Location Danvill	e, Vi	
Balti permit.	Depar Impor any In	21. Signature of Funeral Service L	icensee		Pritts 412 Wa	ashing	of Facility Eral H gton F	Iome & Cha Rd., Westm	pel, P. inster,	A. MD 2	1157
	ysician Medical	23a. Part1. Enter the disease, or o shock, or heart failure. List o	complications that cause only one cause on eech l	d the death. Do ine.	o not enter the mod	de of dying,	such as car	diac or respiratory e	rrest,	1 +	Approximate Interval Between Onset and Death
_	aminer	Immediate Cause (Final disease or condition resulting in death)	e		a consequence of):						1 93/22
8760, cate be executed	physician end s the burial-transit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	b	Perfor	a consequence of):	Div	ertic	Ulum			1 asys
	_ =	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a	consequence of):						
Geath cert	d by the attanding latached for use a Physician/M	Part II. Other significant condition	ns contributing to death t	out not resulting	in the underlying c	ause given	in Part I	23b. Did t	obacco use co	ntribute to	the cause of death?
S, P.O	igned by the bedatache by Phys								res 2√No		ably 4 ☐ Unknown
Hecords, P.O. Box (The law requires that the death certif	spen s should							24a. Was perfo	an autopsy med?	avai	re autopsy findings ilable prior to npletion of cause eath?
	nis cartificate has the director, page 2 s	25. Was cese referred to medical						1□Y	· · · · · · · · · · · · · · · · · · ·	1 🗆	Yes 2□ No
of Vita Physician:	nis cartifie Il director To Be	examiner?	Hospital: 1 Inpatie	ent 2 ER/O	Outpatient 3 DC	Other		Death (Check only o g Home 5 ☐ Resid		er (Specify)	3
DIVISION OF or Attending Phys		27. Manner of Deeth 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Inju (Month, De	ıry 28b.		8c. Injury at Work?		28d. Describe h			
UIVI;	ral Director: After tilled in by the funeral Certification:	3 ☐ Suicide 6 ☐ Could no determin	building, et	c. (Specify)	farm, street, factory			28f. Location (S City or Tow	n, Stete)		
Hosp	he Funer pletely fil edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of xaminer: On the basis of and manner ste	t examination e	e, death occurred a nd/or investigation,	at the time, in my opini	date and pla ion, death or	ace, and due to the occurred at the time, o	ause(s) end ma date and place, e	nner as sta end due to t	ted. the ceuse(s)
Tot	To the	29b. Signature and title of certifier	Loim (d	belma	2	. License ni			29d. Date signed		Dey, Yeer)
	M35	30. Name and eddress of person wi	ho completed cause of d		(Type, Print)	0000	59943	. ا	TIPILL	1, 4	
	State	31. Dete filed (Month, Day, Year)	M.D. 29	∎r's Signature	mer Ave	. Su	ite 3	o7 wes	rminster	M	0 21157
	Registrar	APR 0	1 2004	Muse .	the Same	4.					

State of Maryland / Department of Health and Mental Hygiene 2 1 1

			Decedent's Name (First, Middle, Las	st)		Cen	ificate of	Deam	2. Dete of Dee	eg. No. th	3	3. Time of Death	
	Physici		V. Charles Varano						Month 3-27	Day —∩ /₁	Year	2:30 A.M.	
-	/Medic		4e Fecility Neme (If not institution, give					4b. City, Town, or Lo			ty of Deeth	2.30 A.M.	
1	Examir	ner	Holy Cross Hospit					Cilron Co	rina		•		
			5. Social Security Number 6. S		je (In yrs. les	t hirthday)	If Under 1 Year	Silver Sp			t gomery		
b -	Funeral Director			⊠M 2□F	89	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Dey 11-28	, Year) -14	MS Country)	e (State or Foreign	
	farylend	5	10a. Stete 10b. County			Town or Loca						Inside City Limits 1 ☐ Yes 2 ☑ No	
	28a-1	Ş	MD Montgome 10e. Street end Number	ry	5117	ver Sp	ring 10f. Zip Code			Da Citizan of	Whet Country	2	
	t of	늅											
	23 a	a.	3128 Greenfield R	d. Apt. #		40.146	20904		U.S.A. Decify Yes or No- 14. Race - American Indien,				
020	s 1 and 2 should be flied within 72 hours eftar deeth with the Maryland of Heelth and Mantal Hygiene. If Heelth and Mantal Hygiene. Other traumatic event, the Modical Examiner must be incilled at	by Funeral Director	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 XYes 2 1 If Yes, Give Year or Detes:			Yes, specify Cub	lispenic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)	Bla	ack, White, etc.		
21215-0020	ithin 72 ho he. hen *netur	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or :		16a. Decede (Give ki life. Do	nt's Usuel Occup ind of work done O NOT use retire	e during most of working ed)			Business/Indus	try	
7	od v Pertr	ဒ္		12		Resta	aurant O		(E) . A () . II				
2	al Hoth	To Be	17. Fether's Name (First, Middle, Lest)					18. Mother's Name	e (First, Middle, I	Maiden Surna	me)		
<u>×</u>	Mant	2	Joseph Varano					Angelina	Coreal	9			
Maryland	and and		19a. Informant's Name/Relationship (7					and Number or Run		_			
Σ	elth 27 I		Phyllis R. Varano	- Wife				ld Rd. Ap	t. #405	Silver	Sprin	g, MD 209	
Baltimore,	00-	G	20a. Method of Disposition 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				tion (Neme of etory or other place In Crema				- City or Town,	State	
<u>=</u>	permit. Pag Department Importent: I eny injury o	P	21. Signature of Funeral Service Licen	500		22. 1	Name and Addre	ss of Facility H1	nes-Rin	aldi F.	н.		
Ö	Pen Pen Pen Pen Pen Pen Pen Pen Pen Pen		10	A. I	111	118	800 New	Hampshire	Ave. S:	ilver S	Spring,	MD 20904	
			23a. Part1. Enter the disease, or compshock, or heart failure. List only	olications that secone cause on economic	the deeth.	Do not enter	the mode of dyir	ng, such as cardiac o	or respiratory arm	est,	int	proximate erval Between aset and Death	
T.	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a			Arrythm	ia			1		
		<u>-</u>				s a conseque					į		
	pei isi	듵		b				t Failure			<u> </u>		
	end end I-trer	Examiner	Sequentially list conditions, if env. leading to immediate		Due to (or a	s e conseque	ence of):						
68760,	rificate be executed ng physicien end as the bunel-trensit	edicai	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last			ronary s a conseque		Disease,	Implant	ed Def	ibrilla	ator	
Вох	eath cert attandin I for use	and		d									
	deal he att	Sici	Part II. Other significent conditions co	ontributing to death b	ut not resulti	ng in the und	lerlying cause giv	en in Part I.	23b. Did to	bacco use co	ontribute to the	cause of deeth?	
, P.O.	as that the designed by the a	by Physician/M	Abdominal	Aortic And	eurysm				1 🗆 Y	es 2 No	3 Probab	ly 4 ☐ Unknown	
Records,	sw requir	Completed	Cerebrovas	cular Disc	ease				24a. Was e perform	n autopsy ned?	availal	autopsy findings ble prior to etion of cause th?	
<u> </u>	en: The la tificate ha tor, page	Son							154	E 200 No	1 □ Ye	s 2□ No	
		Be	25. Was case referred to medical					26. Place of Death	(Check only on	e)			
of Vital	Physician: rthis cartific aral director,	10	examiner? 1 ☐ Yes 2X No	Hospital: 1 Inpatie	ent 2 ÆF	VOutpatient	3□ DOA Oth	er: 4 Nursing Ho	me 5□Reside	ence 6 🗆 Otl	her (Specify)		
_	0 0 0		27. Manner of Deeth 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, De	y Year)	8b. Time of Injury	28c. Injur Wor M 1	yat k? Yes 2 □ No	28d. Describe ho	w injury occu	rred		
Division	To the Hospital or Attendin within 24 hours after deeth. To the Funerel Director: Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of Ini	ury - At hom c. <i>(Specify)</i>	e, farm, stree	et, factory, office		28f. Location (St City or Town		ber or Rural Ro	oute Number,	
	he Hospil in 24 hour he Funera pletely fills	edical		ysician: To the best niner: On the basis of end manner sta	f examinetion		stigation, in my o	pinion, death occurr	ed at the time, d	ate and place,	and due to the	cause(s)	
	To with a	Σ	29b. Signature end title of certifier	1/ 2		_	29c. Licens	e number	2	9d. Date signe	ed (Month, Day	, Year)	
			> Adh A	tucker	M	\mathcal{D}	D0	023649		Mar	ch 29,	2004	
		1	30. Name and address of person who o	completed cause of d	eath (Item 2	3e) (Type. Pr	rint)						

			1 - For State Registrar	State of M	aryland /		irtment <i>tificate</i>				Mental Hy	0	0.01	10	l = 0
	Physic /Medi		Decedent's Name (First, Middle, L ANNIE FAITH	VOGEL.							2. Date of D Month Marc	A Day	200	3. Time	of Death
	Exami	ner	4a. Facility Name (If not institution, g SHADY GROVE AD	VENTIST HO	SPITAL		ROC	KVI					OUNTGON		
	Funeral Director		5. Social Security Number 6. NONE Usual Residence of Decedent	Sex 7. Ag	ge (in yrs. last b	Yrs.	Months 4	Pear Days 10	If Under Hours	Min.	8. Date of Bi (Month, D NOV . 1	rth ay, Yeer) 4, 200	_ (Birthplace (Star Country) ARYLAND	
	with the Maryland a or 28a-f show be notified at	Director	10a. State 10b. County MARYLAND MONTGO	MERY	10c. City, Too		cation							10d. Inside	City Limit
	th with ti 23s or 2 ust be n	al Dire	9205 TOWN GATE I.	ANE			10f. Zip 0	081	7			10g. Citize	S. A		
9600	hours after death tural', or itams 23 al Executive coust	by Funeral	11. Marital Status 1 🛣 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 💥 If Yes, Give Year or Dates:		lf lf	/as Decede Yes, specif	y Cuba	ispanic Ori n, Mexicar Specify:	i, Puerto	ecify Yes or No Rican, etc.)		Black, Wh	nerican Indian, nite, etc. VHITE	
Maryland 21215-0036	ithin 72 h ie. ien "netu	Completed	15. Decedent's I (Specify only highest g	Education rade completed) College (1-4or 5		(GIVO K	ent's Usual aind of work O NOT use	done d	lunna mosi	t of work	ing	16b. Kind	of Busines	s/Industry	
121	har th		NONE	NONE		NON	E					NON			
yland	should be find Mental Humarked of	To Be	17. Father's Name (First, Middle, Las HOWARD VOGEL								(First, Middle Y WALKI		mame)		
	and 2 shualth and 27 is mer traum		19a. Informant's Name/Relationship LARRY E. WALKER	(Type, Print)GRANDFATI							I Route Numb				*-
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Is marke eny injury or other traumatic onge.		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ 1 □ Cremation 5 □ Other (Spec	□Removal from State	20b. Place of comete	ery, crema	atory or oth	er place	1		/2004			r Town, State	I.AND
Balt	permit. Departr imports eny inji		21. Signature of Funeral Service Lice	Ototiles	nuels	22. ED	Name and	Addres SAG	s of Facility	NERA	L DIREC	TION.	INC.		20852
	Physician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Extren	ne pre a consequence	not enter	tury with	of dying	7, such as	cerdiac o	istinel	rrest,	aken	Approximinterval Bronset and Bl Co	ate etween
68760,	fficate be executed pypysician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· branchoj	a consequence	any	dy	spla	SG~		371000	Pojer	egye v	131 da	ys.
P.O. Box 6	The law requires that the death certific lie has been signed by the attending p bage 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of the control	2 Fetal death		ctopic pregi					23d.	Date of de Month	livery Day	Year
	w requires that been signed t should be deta	É	Part II. Other significant conditions of Challestanis / the	contributing to death but partie (u	it not resulting in	the und	erlying caus	se giver	n in Part I.		1 🗆 Y	es 2	3 □ Pi		Unknown
of Vital Records,		Be Completed	25. Was case referred to medical	eria					28 Place	of Death	24a. Was a autop perfor 1 Yes	med? 252 No	prior to death? 1 Yes	utopsy findings completion of	available cause of
<u>></u>	is di	2	examiner? 1 □ Yes 2 X No	Hospital: 1 Inpatier	nt 2□ER/Ou	tpatient	3□ DOA	Other			e 5 ☐ Resid		Other (Spe	cifv)	
Division o	ttanding death. tor: After the fune	Certification:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b		Year) Ir	ime of njury	М		at es 2□N	0 2	8d. Describe h	ow injury occ	curred		
<u>≥</u>			4 ☐ Homicide determined	building, etc.	(Specify)						Bf. Location (S City or Tow	n, State)			nber,
	the Hospital in 24 hours tha Funaral pletely filled	edic	one)	nysician: To the best of niner: On the basis of and manner stat	DAAIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	, death o	ccurred at t stigation, in	he time my opir	, date and nion, death	place, ar occurred	nd due to the c d at the time, d	ause(s) and ate and plac	manner as e, and due	stated. to the cause(s	s)
	To the within 2 To tha complet	Σ	29b. Signature and title of certifier	1	ND		7	cense						h, Day, Year)	
,		_	- Maain	completed cause of dea	• .		D	43	125			Marc	h 2	4,200	4
		1	30. Name and address of person who	Completed cause of dea	ath (Item 23a) (9 a a	Type, Pri	nt)	Cer	fer	Duis	e Pa	lestille	Λ	M) - 6	2

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) MAR 2 9 2004

32 Registrar's Signature

		1- State Registrar	State of Ma	ryland / Depa		lealth and M	lental Hyg	_		1245
Physici /Medio		1. Decedent's Name (First, Middle, La: Dorothy Mae Wi					2. Date of Death Month March	Day 2004		Time of Death 9:45 a M
Examir		4a. Facility Name (If not institution, given Dorchester Gener	al Hospita		Camb	ridge			orches	
Funeral Director		5. Social Security Number 6. S 240-26-8974 1 Usual Residence of Decedent	Col-	(In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug. 15	, 1922	9. Birthplece Country) North	(State or Foreign Carolin
Maryland Ited at	tor	10a. State 10b. County Maryland Dorche	ster	10c. City, Town or Lo	cation Cambridg	e				Inside City Limits
with the	Director	10e. Street and Number			10f. Zip Code	613	10	Og. Citizen of WI	hat Country?	
hin 72 hours after death with the Maryland 9. an "natural", or Items 23a or 28a-f show Medical Exana per must be motified at	by Funeral	11.32 Hudson Rd. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 221 If Yes, Give Year or Dates:	0		Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race	- American II , White, etc.	
ain 72 hou II. In "natura Medical E	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	ducation	(Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of worki d)	ing	16b. Kind of Bus	iness/Industr	
d 2 should be filed within the and Mental Hygiene. 77 is marked other than "traumatic event, ILA Men	Сош	12			Homemak	er 18. Mother's Name	(First Middle A	Own 1		
ed is b	To Be	W.A. Collins				Ada Win		aldon barraino	,	
and 2 should Balth and Mer n 27 is marks		19a. Informant's Name/Relationship (Alfred Joseph Wil				on Rd., Ca		•	State, <i>Zip Cod</i> 1613	le)
of H		20a. Method of Disposition 1 □ Burial 2 ★Cremation 3 □ 4 □ Donation 5 □ Other (Specif		20b. Place of Dispo cametery, crea MidShore	esition (Name of matory or other pla eCrematio	nCenter 3		cambr:	ity or Town, idge,	
permit. Page Department of Important: If any injury of		21. Signature of Funeral Service Licer	/6	201	2. Name and Addre	onwell Fundament	neral Ho	me, I.A	2	
Physician /Medical Examiner prize partial-transit	i Examiner	23a. 111. Enter the disease, or comshock, or heart aith. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or rigury that initiated events resulting in death) Last	a. Due to (or a) b. Due to (or as a)	a consequence of):	Prev	moria	n tespitatory and	3 ,	Inte	proximate anval Between set and Death
death certificat e attending phy ed for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Ulive birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnanc	у		23d. Date Mont	of delivery h Day	Year
law requires that the de as been signed by the a 2 should be detached f	by	Part II. Other significant conditions of	contributing to death bu	t not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	acco use contrib		use of death?
The ate h	Completed						24a. Was an autopsy perform	pri led? de	ere autopsy fior to comple eath?	findings available tion of cause of
nysician: Th us certificate director, paç	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 ER/Outpatier	ot out	26. Place of Death			(0	
ing PI	-	1 Yes 2 No 27. Manner of leath 1 Natural 5 Pending 2 Accident investigation	28a. Vate of Injur (Month, Day	y 28b. Time o	28c. Inju	ry at	me 5 Resider 28d. Describe ho			
tal or Attend s after death al Director: .	Certification;	3 Suicide 6 Could not b 4 Homicide determined		ry - At home, farm, str . (Specify)	eet, factory, office		28f. Location (Str City or Town,	eet and Number State)	r or Rural Ro	ute Number,
To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	(Check only 6 Medical Examone)	nysician: To the best on niner: On the basis of and manner sta	examination and/or in	vestigation, in my o	ppinion, death occurr	ed at the time, da	te and place, an	nd due to the	cause(s)
To To COT	Σ	29b. Signature and title of certifier	1 kmos	30	29c. Licens	1793	29	3 34	O 4	r ear)
		30. Name and address of person who	evmier	- D.O	Print) 503	Bygg	25+ (Pamb	idge!	MD3161
Sta Regist	ate	31. Date filed (Month, Day, Year) MAR	2 5 2004 a	r//Signature	Course					

State of Maryland / Department of Health and Mental Hygienes 2004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year JAMES RAYMOND WEICK 815 3 /Medical 26 04 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death REGIONAL Medical SA 1/36UN INSUUA NICOMICO If Under 1 Year If Under 24 Ars. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 8-16-1950 9. Birthplace (State or Foreign Country) NEW JERSEY **Funeral** Days Hours 1 ₹ M 2 □ F 53 Yrs. Director 135-44-3895 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location : If item 27 is marked other than "natural", or items 23s or 28s-1 show or other traumatic event, the Medical Examinal must be notified at 10d. Inside City Limits Director DELAWARE SUSSEX 1 ☐ Yes 2 ☑ No SELBYVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 SAND DOLLAR LANE 19975 US Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No 3 Widowed 4 Divorced WHITE Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 CARPENTER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental JAMES C. WEICK GRACE MARY SHILES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra JANET WEICK/ WIFE 16 SAND DOLLAR LANE, SELBYVILLE, DE. 19975 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State MELSON S CAPE 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4 Donation HENLOPEN CREMATORY 3-28-04 FRANKFORD DELAWARE 21. Signature of Funeral Service MELSON FUNERAL SERVICES, LTD WEST AVE, OCEAN VIEW, DE. 19970 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failud. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Stroke 2 duys /Medical Due to (or as a consequence of): Examiner Hypertensis. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.0. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 90 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate performed? 1 Yes 2 NO Hospitat or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury after death.
I Director: Af
d in by the fu 1 Tyes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Dire 4 Homicide Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0015697 27/04 completed cause of death (Item 23a) (Type, Print) obert 130 T18 Newby ST 31. Date filed (Month, Day, Year) 32. **gistrar's Signature State 2004 Registrar

Neick, James R

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Z **Physician** 70 LEON PETER WLAZLOWSKI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Atlantic General Hospital Worcester Berlin If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** 1**X**) M 2□ F Yrs. 9/8/1935 NJ 68 152-26-2767 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Modical Ext. After roust be notified at 1 XYes 2 No Director Berlin MD Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 73 Bramblewood Dr. 21811 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) City Fire Dept. Firefighter 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Z. Frank Wlazlowski Pauline Teems 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 73 Bramblewood Dr. Berlin, MD 21811

f Disposition (Name of 20c. Location - City or Town, State Maureen Wlazlowski 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3/24/04 1 Burial 2 Cremation 3 Removal from State Cape Henlopen Crematory 4 ☐ Donation 5 ☐ Other (Specify) Frankford, DE 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licensee M00281 St. Berlin, MD 21811 endim Approximate Interval Between Onset and Death is bart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feliure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to as a consequence of): Examiner Sequentially list conditions, ray leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): 3/20/2004 Box 68760, by Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 242 o 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, page 2 should be 3 Probably 4 □Unknown 1 ☐ Yes 2 ☑ No Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 / NO Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 ☐ Yes 2 ☐ No 1 XInpatient 2 ER/Outpatient 3 DOA Certification: To ot 3 27. Mann of Death 1 Watural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Division 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Diractor: A 2 ☐ Accident 1 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Durkin, DO 9733 Healthway Dr. Berlin, MD 21811 31. Date filed (Month, Day, Year) MAR 23 2004 State Breva Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Patricia

State of Maryland / Department of Health and Mental Hygiene 004 12463 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)
Mary 2. Date of Death 3. Time of Death April 8, **Physician** 2004 Virginia Whitmore 10:35A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Hours Months Days 1 □ M 212 F Director 80 1924 220-16-1564 3, Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or than "natural", or itama 23a or 28e-f show the Modical Extractor coust be notified at 1 ☐ Yes 2 ☐ No |Maryland|Frederick Middletown Direct 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 7909 Brookridge Drive 21769 USA Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Yho
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ➡Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) is marked other than Accounting Clerk County Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mental pe Smith Jessie Kershaw John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an permit. Pages 1 and 2 to Department of Health ar importent: if itam 27 is any injury or other traugonce. Ron Whitmore/Son 11010 Baker Road Keymar, MD 21757 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hope Cemetery 4/10/2004 Woodsboro, MD 22. Name and Address of Facility Stauffer Funeral Home, PA 40 Fulton Avenue Walkersville, MD 21793 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Lis may one cause on each line. 23a. P. 11. 3nto the diseas shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final and exercition Uhr. **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to for as a consequence of r. Examine certificate be executed burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the as attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) o the detached 9 Unknown signed by t ۵. Part II. Other significant conditions contributing to death but not résulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 182 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 ☐ Yes 210 No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dinpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this After thi 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: Division 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after after To the Hospital o within 24 hours aft To the Funaral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Muy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Yeer **Physician** WEDDLE, ROBERT JR. 2004 L. 2130 April /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2□ F 69 217-30-7115 JAN.5, 1935 Maryland Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Frederick Frederick Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23s or 21702 8335 Edgewood Church Rd. United States Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Interest if it is 27 is marked other than "natural", or iter important: if item 27 is marked other than "natural", or iter examines orly injury or other traumatic event. The Medical Examines ones. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coltege (1-4or 5+) Elementary/Secondary (0-12) 12 Aluminum Caster Aluminum Manufactuer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sr. Weddle, Maude Robert L. Hetterly ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Weddle / wife 8335 Edgewood Church Rd. / Frederick, MD Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 04/08/2004 Woodsboro, Maryland Mount Hope Cemetery 22. Name and Address of Facility Stauffer funeral Homes, P.A. 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike/ Frederick, MD saymond 23a. Pert 1. Ener the disease, or complications that caused the district Do not enter the mode of dying, such as cardiac or respiratory arrest, shock to heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Due to (or as a consequence of): /Medical ma Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as I consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No o 9 Unknown ate has been signed by page 2 should be detacl ئ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Junknown 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ NO 24a. Was an this certificate has 1 Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2010 2 PER/Outpatient 3 DOA 1 Yes Medical Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury Hospital or Attending 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident within 24 hours after death. To the Funeral Director: A the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 certia 220 31. Date filed (Month, Day, Vear) 32. Registrar's Signature State Registrar APR 0

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			For	State of Maryla		nt of Health and	Mental Hygie	ne on o	101.05
			1 - State Registrar		Certifica	te of Death		No.2004	1 42 1 0 0
	Physici	an	Decedent's Name (First, Middle, Last)	lamilton	William		2. Date of Death Month	Day Yeer	3. Time of Death
	/Medic	al						30, 2004 4c. County of Deal	i.u.p.
	Examin	er	4a. Facility Name (If not institution, give: 2641 Walter			Town, or Location of Deet	ri	Somer	
	Funeral		5. Social Security Number 6. Sec		s. last birthday) If Unde	er 1 Year If Under 24 Hrs			thplace (State or Foreign buntry)
	Funeral Director			M 2 F 9	Yrs. Months	Days Hours Min.	(Month, Day, Yo		aryland
	D .		Usuel Residence of Decedent						
	arylar ehow	پ	10a. State 10b. County	-7	City, Town or Location	1. E. ()			10d. Inside City Limits 1 ☐ Yes 2 1 No
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	with ti	D	10e. Street and Number	Tours !	7	ip Code	10g	. Citizen of What Co	ountry r
	eath	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13. Was Deci	21817	Specify Yes or No-	14. Race - Ame	encen Indian,
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3	el', o	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	20 No Specify:		Specify: B	1ACK
215-0036	within 72 hours after death with the Maryland ene. Itan "naturel", or items 23a or 28a-f ehow tra Madical Exeminar mast be natilied at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Decedent's Usi (Give kind of w	ual Occupation ork done during most of wo use retired)	rking 16	b. Kind of Business	. 1
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and	a la p	Be c	WALLACE W	11/1Ams		F110	0	OUTHE	
5	should ind Men marke umatic	To	19a. Informant's Name/Relationship (Ty	1	19b. Mailing Addres	ss (Street and Number or R			Zip Code) 21817
Mar	s 1 and 2 should f Health and Mer ftem 27 le marke other traumatic		WANDAF	proliviece	210669	11	nes Rd.	Cris Fix	ld Wid.
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altimore,	permit. Page Department of Important: If eny injury or ance.		21. Signature of Funeral Septice Cons			and Address of Facility			
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			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the de ne cause on each tine.	eath. Do not enter the mo	de of dying, such as cardia	c or respiratory arrest	,	Approximate interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a	GASTRIC	LARCINOI	MA		Oriset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):				
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	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a cons	equence of):				
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9	death certificate l e attending physi od for use as the b	edlo							
X R O	h cert andin	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. ff yes, outcome of preg 1□Live birth 2□Fe		oreonancy		23d. Date of de	,
ם מ	0 0 2	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of				Month	Day Year
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ပ္	law as t	Completed					24a. Was an autopsy performed	24b. Were at prior to death?	utopsy findings available completion of cause of
	icate ha						1□ Yes 2V		2 □ No
	Attending Physician: The death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Debio	Other	ath (Check only one)		
ō	Physical dis	: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 3 0	28c. Injury at Work?	lome 5 Residence 28d. Describe how		city)
0	th: : Afte	tior	1 Natural 5 Pending investigation	(Month, Day Year)	Intury M	Work? 1 ☐ Yes 2 ☐ No			
DIVISION	Atter r dea ector by the	ifica	3 Suicide 6 Could not be determined	28e. Pface of Injury - Al	t home, farm, street, facto	ory, office	28f. Location (Stree City or Town, S	at and Number or Ri	ural Route Number,
5	al or	Certification:	4 Homicide	building, etc. (Spe	icity)		City of Town, S	nate)	
	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral			sician: To the best of my kiner: On the basis of exami					
	the H iin 24 the Fi iplete	Medical	one)	and manner stated.					
	To To	2	29b. Signature and title of certifier	\wedge 1	2	9c. License number D 4809	29d.	Date signed (Mont	-
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			30. Name and address of person who c			ALL Huy	00.05	ELD M	D 21817
	Sta	to	V. KARUMBUA 31. Date filed (Month, Day, Year)	32. Register's Sic	201 H		CRISFI	red M	0 01011
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene or pro-

		•	For State Registrar	State of Maryla	•	artment of H rtificate of I			Reg. No.	+ 12466
	Physicia	an	Decedent's Name (First, Middle, Last) B	EVERLY MAR	IAM WI	LLIAMS		2. Date of Dea Month MARCH	Day Year	3. Time of Death 3:50 P M
*	/Medic Examin		4e. Fecility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	THITCH	4c. County of Dee	
	-		CARROLL HOSPITZ				MINSTER		CARRO	
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	/land	}	Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	ocation				10d. Inside City Limits
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	with the or 20	Dire	10e. Street and Number			10f. Zip Code 2115	7		10g. Citizen of What C	ountry?
	death with the Maryland ims 23e or 28a-f ehow r numl be notified at	neral	25 MONROE ST. 11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of H		ecity Yes or No		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene it the Marylan tem 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Medical Establiner mant be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No		riicari, etc.)	Specify: WI	•
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121	within liene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		TH CARE			HEALTH	
pu	al Hygi I other	BeC	17. Father's Name (First, Middle, Last)			- 0			Maiden Sumame)	
yla	ould b	70			NCE RI		HONEY		INCHAM ar, City or Town, State,	Zin Codol
Mai	nd 2 sh lth and 27 is n traun		19a. Informant's Name/Relationship (T) JACK HOHN	- SON		•				R, MD.21157
	of Heal		20a. Method of Disposition	206	. Place of Dispo	osition (Name of matory or other place		Date	20c. Location - City o	
imo	A = 0		1 ☐ Burial 2 ② Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	AL:		TY CREMA			SYKESVIL	
Baltimore,	permit. Pag Department Important: eny injury o		21. Signature of Foreral Service Licens	00					FUNERAL INSTER, M	
			23a. Pert1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the de ne cause on each line.	eath. Do not en	ter the mode of dyin	. /		rrest,	Approximate Intervat Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Adult A	esp110	story () (Sheir	Syl	if me	mays
Н	Examiner			Due to (or as a cons	equence oi).					/
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	= 00.61		IF FEMALE:	20-16						_
Box	leath certifi attending I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	☐Ectopic pregnancy ☐ Other (specify)	/		23d. Date of de Month	Day Year
Ö.	thet the dended by the a	hysi	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown						
rds, P	The law requires thet the death cert the has been signed by the attending tage 2 should be detached for use	þ	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	underlying cause giv	en in Part I.		obacco use contribute Yes 2□No 3□F	\/
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ital		Be C	25. Was case referred to medical				26. Place of Deal			3 10
of V	Physicien: r this certific ral director,	ပ	1 195 25 10		ER/Outpatie		4 Nursing no		dence 6 Other (Sp	ecify)
	ling After une	tion:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year	28b. Time o Injury	Wor	yat k? Yes 2 □ No	28d. Describe	how injury occurred	
Division	I or Attending after death. Director; After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st ecify)			28f. Location (a City or Tou	Street and Number or F vn, State)	Rural Route Number,
_	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	edical Ce		vsicien: To the best of my iner: On the basis of examand manner stated.						
	To the within To the comple	Mec	29b. Signature and title of certifier	L		29c. Licens	se number	13	29d. Date signed (Mor	nth, Day, Year)
			· ~	110	10	DD	0445	66	Hpril 1	1,2004
	MIL	-	30. Name and address of person who c				ROLL HOSP			MD 21157
	Sta	ate	ENRIGO (TIP 31. Date filed (Month, Day, Year)	NGERUS (32. Regionar's Si		JU PIEMOR	TAL AVE	·, WES	TMINSTER,	MD.21157
	Regist		APR 0.2	2004 Magne	. K	Boret 1				

WILLIAMS BEVERLY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 2004 11:47 AM Fred Junior Williamson 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Cecil Elkton Union Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. (Month, Day, Year) March 17, 1926 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 11 M 2 □ F VA 227-28-4810 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County 1 Yes 2 No Cecil Port Deposit MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 1020 Hopewell Road 21904 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Polces: 1 (X) Yes 2 □ No If Yes, Give Year or Dates: (W(W 11 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specity: White 3 XWidowed 4 □ Divorced 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Machineru 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Annie Fletcher Roland Williamson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1020 Hopewell Road, Port Deposit, MD 21904 Penny Styer/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 04-08-2004 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State R.T. Foard Funeral Home, P.A. Rising Sun, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility R.T. Fourd Funeral Home, P.A. 111 S. Queen Street, Rising Sun, MD 21911 21. Signature of Funeral Servicensee Approximate Interval Between Onset and Death Y pox evice 4000 Due (or as a consequence of): Exacerbaton OPD - Emphylona Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cardionyofatyy 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed effusions 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year)

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

r then "naturel", or Items 23e or 28e-f show the Medical Examiner rust be notified at

Baltimore, Maryland 21215-0036

Director

Funerai

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permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturer, or item any injury or other treumatic event, the Martines once. 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final dis a se or condition reading in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Physician/Medicai IF FEMALE 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 s 25. Was case referred to medical examiner? To Be 1 Yes 2 No 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident nerel Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) within 24 hours a 29a, Certifier Medical 29b. Signature and title of certifier 00055190 wo MO

28t. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 7, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Union Hospital 106 Bowstreet Elkton, MD A Alfred MD 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

APR 0 8 2004

241

State of Maryland / Department of Health and Mental Hygiene 2001.

D.C.

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 XYes 2 No

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	1 - State Registrar Co	ertificate of Death	Re	000	16	- 13 E)	
	Decedent's Name (First, Middle, Last)		2. Date of Death		V	3. Time	e of Dea	ath
ian cal	Virginia Wallace		MARCH	30	2004	11:1	11 A	
	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. Cou	unty of Death			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

/Med Exami

Directo

à

Physic

Funeral Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at

IRGINIA WALLACE

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

Be

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Certification:

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27. Manner of Death 1 Naturat

2 Accident

3 Suicide

29a. Certifier

4 Homicide

burial-transit attending physician use as the ō ed by the a

To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics

Division of Vital Records, P.O. Box 68760

Doctor's Community Hospital Prince George Lanham | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Under 1, 1947) | Hours | Min. | Hours | July 17, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1□M 2X F Yrs 1929 74 Wash., 577-42-8080 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Prince George Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20783 U.S.A. 1836 Metzerott Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2X☐ If Yes, Give Year or Dates: 1X Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government Clerk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Arthur Wallace Mattie Briscoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5525 2nd St., NW, Wash., D.C. 20011 Edward Wallace/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 4-5-2004 4 □ Donation 5 □ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature # Funeral Sprvice Cicylo ee 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month

in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed 2 1 No

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Day

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury (Month, Day 28b. Time of 28c. Year) 5 Pending investigation

Injury at Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

6 ☐ Could not be

determined

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

AM IRALI AM JANI 8/18 Cm ed Luch Rd

31. Date filed (Month, Day, Year) State Registrar

APR 0 2 2004



			For State Registrar	State of Maryla		artment of I		nd Mental H		2004	12470
T	Division		Decedent's Name (First, Middle, La	ast)				2. Date of D			3. Time of Death
	Physicia /Medic	al	CHARLES DUKE WI			4b. City, Town, o	or Location of	MARCI		2004 County of Death	2:29P M
	Examin	er	LAUREL REGIONAL				UREL			PRINCE G	EORGES
Ī	Funeral		Social Security Number 6.	Sex 7. Age (In yi	s. last birthday)	If Under 1 Year Months Days		Min. (Month, L	Birth Day, Year)	9. Birth	place (State or Foreign
	Director		579 64 8700 Usual Residence of Decedent		55 Yrs.			JAN. ()5, 1	949 WASH	INGTON, DC
	iryland show	_	10a. State 10b. County	10c.	City, Town or Lo	ocation					10d. Inside City Limits XXYes 2 □ No
	he Ma 28e-1 s	Director	MARYLAND MONTGOM 10e. Street and Number	ERY BU	RTONSVI	LLE 10f. Zip Code			10a. Cit	izen of What Cou	1
	3e or		3921 DUNES WAY				0866			TED STAT	
	ems 2	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.			in? (Specify Yes or N Puerto Rican, etc.)	10-	14. Race - Ameri Black, White,	
36	hours after death with the Maryland Lurel', or Items 23e or 28e-1 show al Ezali, incr must be notified at	by Fu	1 ☐ Never Married	1 ☐ Yes 2 → No If Yes, Give Year or Dates:		1 ☐ Yes 2/CXNo	Specify:			Specify: BLA	CK
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Maryland	2 should be and Mental is marked c	To B	CHARLES D. WILLIA	MS, JR.				HA KELLY			
lar)	2 sho and I is me		19a. Informant's Name/Relationship					or Rural Route Num			
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene it the Health and Mental Hygiene item 27 is marked other than "neture!", or Items 23e or 28e-1 show other treumetic event, I'm Madical Exal, in armust be notified at		20a. Method of Disposition		. Place of Disp	DUNES W. osition (Name of or other pla		BURTONSV:		ocation - City or T	
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Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signalure of Functal Service Lis	Asoo aushall				AL HOME O			
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89	tificate ig phys as the			d							
Вох	death certifica e attending ph id for use as th	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	etel death 3	□Ectopic pregnanc	;y		1	23d. Date of deliv Month	ery Day Year
0		Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at time o 9⊡Unknown	of death 5	☐ Other (specify) _					
S, D.	requires that the been signed by th hould be detache	by Ph	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause gr	ven in Part I.	23e. Dio	d tobacco i		the cause of death?
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Ţ	Physicien: rthis certific ral director,	To Be	examiner? 1XXYes 2 □ No	Hospital: 1 ☐ Inpatient	⟨X ER/Outpatie	ant 3 DOA	her: 4 □ Nur	sing Home 5 ☐ Re		6 □Other (Speci	(fy)
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/isic	eat or:	flcat	2 Accident investigat 3 Suicide 6 Could not	be 28e. Place of Injury - A				28f. Location	(Street an		al Route Number,
á	i di di ⊆	Certification;	4 Homicide	building, etc. (Sp	ecity)			City of 1	OWII, State		
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)	(10)		* Krchurel	Vy Court	um	MD :	1166		MAR	CH 30, 2	2004
)	(13)		30. Name and address of person whe RICHARD M. KAUF	1./	Item 23a) (Type A . C . P .		9TH ST	. NW #200	WASH	IINGTON,I	OC 20036
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 0 2 200	2. Registrar's Si	gnature for	de					

		1	State of Maryla State Registrar		artment of He rtificate of D			Reg. No.	004	12471
	Physicia	an	Decedent's Name (First, Middle, Last) MAUDE N. WILLIAMS				2. Date of D Month March	Day	04 Year	3. Time of Death 10:55A M
	/Medic Examin	A 186	4a. Facility Name (If not institution, give street and number) PRINCE GEORGE'S HOSPITAL		4b. City, Town, or L CHEVERL	ocation of Death		4c. Cc	nunty of Death	_
#1 #2 #2 #2 #2 #2 #2 #2 #2 #2 #2 #2 #2 #2	Funeral Director		238-60-0368 ¹ \\$\text{X}M 2□F 65	rs. last birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of B (Month, D 11 2	irth <i>1ay, Year)</i> 1 193	9. Birth Cou 8 Nort	place (State or Foreign intry) h Carolina
	yland now		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	ocation					10d. Inside City Limits
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	with the or 2	Dire	10e. Street and Number 701 AVANTI PLACE		10f. Zip Code 20785				of What Cou	intry?
920	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Health and Mental Hygiene. ortant: If item 27 ie markad othar then "natural", or itams 23a or 28a-f ehow injury or other traumatic event, Ita Madical Examinational Lancillis of all injury or other traumatic event, Ita Madical Examinational Lancillis of all .	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes Cive Year or Dates:		Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto Specify:	cify Yes or N Rican, etc.)	lo- 14.	Race - Amer Black, White pecify: BL	, etc.
21215-0036	within 72 ho sne. Ihen "naturi e Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1 2 t h	(Give	dent's Usual Occupati kind of work done du DO NOT use retired) EWIFE	on ring most of worki	ng		of Business/le	ndustry
N	id be filed with ental Hygiene. kad othar ther ic event, Ital	To Be Co	17. Father's Name (First, Middle, Last) JAMES D. JOHNSON			8. Mother's Name	(First, Middl JOHNSO		mame)	
Maryland	and 2 should be saith and Mental n 27 le markad o	-	19a. Informant's Name/Relationship (Type, Print) LEMUEL WILLIAMS/HUSBAND	19b. Mailir 701	ng Address <i>(Street an</i> AVANTI PLA	d Number or Rura CE LANDO	VER, M	ber, City or T IARYLAN	own, State, Zi ID 2078	p Code) 5
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 eny injury or other tr once.		1 GRurial 2 Cremation 3 Demoval from State		osition (Name of matory or other place) Veteran's	4/6/2	2004		ion - City or TENHAM,	own, State
Balt	permit. Departr Importe eny inje		21. Signature of Funeral Service Licensee		2. Name and Address 474 LANDUN		B. JEI ANDOVI	NKINS I	FUNERAI KYLAND	HOME 20785
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ivision	or Attending Ph ter death. irector: After th n by the funeral	Medical Certification;	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Yea) 28a. Place of Injury (Month, Day Yea) 28b. Place of Injury 28b. Place of Injury 28b. Place of Injury 28b. Place of Injury 28b. Place of Injury 28b. Place of Injury 28b. Place of Injury 28b. Place of Injury 28b. Place of Injury 28b. Place of Injury 28b. Place of Injury	Al home, farm, str		s 2 No	281. Location City or T	(Street and fown, State)	lumber or Rui	ral Route Number,
۵	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	dical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my one) 1 Medical Examiner: On the basis of examiner and manner stated.	knowledge, deat nination and/or in	th occurred at the time evestigation, in my opin	, date and place, nion, death occurr	and due to the	e cause(s) ar e, date and pl	nd manner as ace, and due	stated. to the cause(s)
	To the within comple	Me	29b. Signature and time of confider)		570		4/	igned (Month	7
R	(2)		30. Name and address of person who completed cause of death by Babana Razi	300	Print) 1 HOSP	1-1 D).,	Ches	erlyi	MD 2078
	Regist	ate rar	31. Date filed (Month, Day, Year) APR 0 2 2004	k April	W					

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		For State Registrar	State	of Marylan		oartmer e <i>rtifica</i>			ınd M		giene Reg. No.	00	04	12472
Dhusisis		1. Decedent's Name (First, Middle,	Last)			· ·				2. Date of De Month		,	Year	3. Time of Death
Physicia /Medic		Rosetta W								March	Day 28		04	4:30 P M
Examin	er	4a. Facility Name (If not institution,				4b. City		Location o		^	4c.	County o		George's
		Crescent Ci 5. Social Security Number	S. Sex	7. Age (In yrs.		v) If Unde	r 1 Year				th		9. Birtho	lace (State or Foreign
Funeral Director		204-24-9793	1 □ M 2 💢 F		33 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Mar • 2,	$19^{(y, Year)}$		Coun	ty) h Carolina
		Usual Residence of Decedent												
arylar show	_	10a. State 10b. County		10c. Cit	y, Town or								11	0d. Inside City Limits 1 Yes 2 No
Ba-f	Director	PA					hilac Code	delph:	ia		10a Citi	zen of Wi	hat Coup	71
with the or 2		10e. Street and Number 849 N. 47	+h C+			101. 21		19139			rog. Citi.			States
filed within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene Hygiene with than "naturel", or Items 23a or 28a-f show out, it a Marical Examiner must be natified a	Funerai	11. Marital Status	12. Was De	cedent Ever in U	.S. 13	3. Was Dece			gin? (Sp	ecify Yes or No Rican, etc.))~	14. Race	- Americ	an Indian,
ifter d		1 □ Never Married 2 □ Marrie	Armed F	2 X No					, Puerto	Rican, etc.)		Black Specify:	, White, e	
rel', o	l by	3	If Yes, G Year or	ilve Dates:		1 🗆 Yes	2 LAI NO	Specify:				Specify:	рта	ick
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within no. than	mpi	Elementary/Secondary (0-12)	College	(1-4or 5+)	lire	Hosp		, Worke	er			State	e Go	vernment
filed v Hygie ther t		12th 17. Father's Name (First, Middle, L	ast)		1	F				e (First, Middle,				VOLIMOTO
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permit. Pages 1 and 2 should be filed within 75 Department of Health and Mental Hygiens Importent: if item 27 is marked other than "in any injury or other treumatic svent, If a Maria	-	19a. Informant's Name/Relationsh			19b. Ma	iling Addres	s (Street a	and Numbe	r or Rur	al Route Numbe	er, City o	r Town, S	tate, Zip	Code)
and 2 alth a 27 is		Bernetta Davi	s - Niec	e	4()11 Ha	nson	0aks	Dr.	, Lando	ver,	MD	207	'84 ———————
of He of He roth		20a. Method of Disposition 17 Burial 2 ☐ Cremation	3 Demoval from		lace of Dis emetery, c	position (Na rematory or	me of other place	θ)	[Date	20c. Lo	cation - C	City or To	wn, State
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epartr epartr nport ny inj		21. Signature of Funeral Service L	4			22. Name a			-	ewart F				
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Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		rteroscl		c Car	diova	scula	ar D	isease				Years
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or A	ertif	4 ☐ Homicide determi	ned 200. Fla	ce of Injury - At h Iding, etc. (Specia	(y)	Stieet, lacto	y, once			City or To	wn, State,)	OI TIUI AI	Triodio Nambor,
spitel lours nerel			Physician: To t											
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To th withir To th comp	Me	29b. Signature and title of certifier	1 0	1			c. License	number			29d. Date	e signed	(Month, L	Day, Year)
7		Paul	len	Leve	166			D0185	52			Marcl	h 30	, 2004
(5)		30. Name and address of person v					_1	D 1	77		11	M	207	01
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Sta Registr		31. Date filed (Month, Day, Year) APR 0 1 201	34	Registrar's Signa	Land	11								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year WILLIE J. WILLIAMS 11:05P^M 26, March 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** †**∑** M 2□ F 245-46-1001 Yrs Director 9-14-34 N.C Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene. other than "netural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits MD. Prince Georges Oxon Hill 1 Yes 2 □ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 824 Shelby Drive 20745 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: Specify: Black 1 ☐ Yes 🌠 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ring most of working Self-Employed Elementary/Secondary (0-12) College (1-4or 5+) Plumber 12th 17. Father's Name (First, Middle, Last) pe mit. Pages 1 and 2 should be file Departrent of Health and Mental Hy Im ortent: If item 27 is marked oth any injury or other treumatic event 2018. 18. Mother's Name (First, Middle, Maiden Surname) Be Pear Williams Drusie Little ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertha M. Anderson/Sister 824 Shelby Dr. Oxon Hill, Md. 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Inglewood Park Cem 4/6/04 Inglewood, Ca. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Robert O. Freeman Fun. Svc. ta Part 1. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hacker Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Metastati disease or condition resulting in death) Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by omprossion 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2 1 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Thipatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined thin 24 hours after de the Funeral Directo mpletely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗜 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SKIN STON M.D.

DHMH 17 Rev 1/2001

State

Registrar

H. Herbert

31. Date filed (Month, Day, Year)

MAR 3 1 2004

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hysiciai		1. Decedent's Name (First, Middle, Las					2. Date of De Month	Day	Year ,	3. Time of Death
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xamine	r 4	4a. Facility Name (If not institution, give				or Location of Death	1	4c. County		1 .
		Doctor's Hospita 5. Social Security Number 6. Se		rs. last birthday)	Lanham If Under 1 Year	If Under 24 Hrs.	R Date of Bir		e Georg	
neral ector			M 2□ F 83	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Feb. 2	y, Year) 1, 1921	Country	
A H	-	10a. State 10b. County	10c.	City, Town or Lo	cation	-			10d	I. Inside City Limits
	Ď,	Maryland Prince Ge	orge's L	anham						1 ☐Yes 2 ☐ No
288		10e. Street and Number	, o		10f. Zip Code			10g. Citizen of	What Country	/?
23a		10408 Lowmoor Ct.			20706			U.S.A.		
if item 27 is marked other than "natural, or items 23s or 28s-r show or other traumatic event, the Madical Examilian in the middle of the contract of the middle of the contract of the contra	by Funeral	11. Marital Status 1	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2▼ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 Yes 2 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		ce - American ck, White, etc	D.
atura cul E	Ted	15. Decedent's Ed	ucation	16a Dece	dent's Usual Occup	pation		16b. Kind of B		
na na	Completed	(Specify only highest grad	College (1-4or 5+)	life.	KIND OF WORK DONE DO NOT use retire	during most of worl d)	king			
vent, tre Me	0	10		Furri	er			Garmen	t	
d oth	e C	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden Sumar	ne)	
natic	0	UNK.				Beatrice				
raumatic ev	1	19a. Informant's Name/Relationship (7)		1		and Number or Ru			, State, Zip Co	o <i>d</i> e)
othar tra	-	Margaret Savage / 20a. Method of Disposition		LU4U8 b. Place of Dispo		Ct. Lanh	am, MD.	20/06 20c. Location	City or Town	State
Important: If item 2 any injury or othar i once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Removal from State No	orthern ematory	Virginia	20	h 29, 04	Arling	ton, Vi	
any in		21. Signature of Funeral Service Licens	les			ess of Facility Ar airfax Dr	-			a 22203
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d be det	λα	Part II. Other significant conditions co	6/.1-	resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use con	tribute to the	cause of death?
should		C/h. Yum	((()))	Juen	1 hour	y our	1 🗆 1	res 2□No	3 Probab	ly 4 □Unknown
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he fu	Catil	2 Accident investigation			M 1 🗆	Yes 2 □No				
d in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	t home, farm, str ecify)	eet, factory, office		28f. Location (5 City or Tox	Street and Numb vn, State)	er or Rural R	oute Number,
ly fill	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	vsician: To the best of my iner: On the basis of exam and manner stated.	knowledge, death ination and/or in	n occurred at the tir vestigation, in my o	me, date and place, ppinion, death occur	and due to the red at the time,	cause(s) and madate and place,	anner as state and due to th	ed. e cause(s)
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	-		ampleted serves of death /	Itam 22a) (Tuna	Deina)	- /		1	(
		30. Name and address of person who o	ombiered canže či destu (nem zsa) (Type,	Print)		/			

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Funeral Director			_ м 2ŒF 55		Months Days	Hours Min.	Jan. 27,	1949	Country) Texa	(State or Fore
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r 288	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Country?	,
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E 5	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of I	dispanic Origin? (Spean, Mexican, Puerto	cify Yes or No-		- American I	ndian,
or Ite	Ē	1 X Never Married 2 ☐ Married	1 ☐ Yes 2 X No		_		nicari, etc.)		, White, etc.	
- 3	b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify:	Whit	ce
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of Head		20a. Method of Disposition		lace of Dispo	sition (Name of natory or other pla	ce)	ate	20c. Location - 0	City or Town,	State
ut; #		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)			e's Cemete		/2004	Glenn D	ale N	Marylan
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burial-transit	dical Examiner	Sequentially list conditions, if any, leading to unfinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the total conse	Colon (Cancer					
ned by the attending physical detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of do	Ideath 3□	Ectopic pregnanc	,		23d. Date Mont	of delivery th Day	Year
sign d be	by	Part II. Dther significant conditions co	ntributing to death but not resu	ulting in the ur	nderlying cause gr	ren in Part I.		oacco use contrib es 2 □ No 3		
been shout	Completed						24a. Was a	24h W	ore autoney	findings availal
has je 2	d LL						autops	y pr	ior to comple	tion of cause of
certificate ha		_					1 ☐ Yes 2	No 1	Yes 2	l No
certific rector.	Be	25. Was case referred to medical examiner?	Hospital:		O#	26. Place of Death				
this al dir	2	1 195 2/21/10	1 Inpatient 2		1 3LI DON	er: 4 Nursing Hon				
After tuner	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo		8d. Describe ho	w injury occurre	d	
within 24 hours after death. To the Funeral Director; After completely filled in by the tuner	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify			Yes 2 ☐ No	8f. Location (Sti City or Town	reet and Number	r or Rural Ro	ute Number,
24 hours at e Funeral D etely filled i		29a. Certifier 1 M Certifying Phy (Check only 2 Medical Exam)	sician: To the best of my kno- ner: On the basis of examinal	wledge, death	occurred at the ti	ne, date and place, a	nd due to the ca	iuse(s) and man	ner as stated	1.
he F plete	edical	one)	and manner stated.	non and or m	osugation, in my C	pinon, deam occurre	o at tite time, da	are and place, ar	u uue to the	cause(s)
within 2 To the complet	Σ	29b. Signature and title of certifier	M		29c. Licens	e number	29	9d. Date signed	(Month, Day,	Year)
		1			M	D20740		March	29, 2	2004
			ampleted seven of death fire	00-1 (T			1			
2		30. Name and address of nerson who co	DISPURIED CAUSE OF DEATH (ITAIT	1232) (VD9	Print)					
0		30. Name and address of person who co Gerard H. Harris,				Sto //	00 170-	hinatas	D.C	20010

			1- For State of Maryland /		rtment of Health and tificate of Death		ene 2004	12476
			Decedent's Name (First, Middle, Last)			2. Date of Deat		3. Time of Death
	Physici /Medio		WARDELL WYNN			MARCH	23, 2004	1435 P M
1	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea		4c. County of Death	1 1133 1
			1100 OWENS ROAD		OXON HILL		PRINCE GI	TOPOFC
	Funeral	177	5. Social Security Number 6. Sex 7. Age (In yrs. last bi	irthday)	If Under 1 Year If Under 24 Hr	s. 8. Date of Birth	9 Birthr	place (State or Foreign
	Director		579-62-0645 ^{14\(\Delta\M\ 2\Gamma\F\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\}	Yrs.	Months Days Hours Mir	MOnth, Day,	7,1948 Coui	N C
	p		Usuel Residence of Decedent					110
	arylan show	_	10a. State 10b. County 10c. City, Tow	wn or Loc	cation		1	10d. Inside City Limits
	Ba-f	ç	MD PRINCE GEORGES OXON	HI	LL			1 X Yes 2 No
	or 2	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cour	ntry?
	23a		1100 OWENS ROAD		20745		USA	
	er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	Vas Decedent of Hispanic Origin? (Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White,	
36	or li	by Ft	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No		☐ Yes 2♥ No Specify:	,	Specify: BLA	
8	4 within 72 hours after death with the Maryland liene. r than "natural", or Items 23a or 28a-1 show the Medical Exardrer must be ricified at	d b	3 ☐ Widowed 4 ☑ Divorced Year or Dates:		••			
5	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupation and of work done during most of wo	orking 1	6b. Kind of Business/In-	dustry
12	within iene. than	E	Elementary/Secondary (0-12) College (1-4or 5+)		O NOT use retired)			
2		e C	17. Father's Name (First, Middle, Last)	MA	NAGER 18 Mother's Na	me (First, Middle, M	RIVATE IN	DUSTRY
Maryland 21215-0036		8	UNKNOWN		Willie			
2	thould Me mark mark matic	ို		h Mailine	WITITE Address (Street and Number or F		Wynn	2-4-1
Z	d 2 s th an th an trau		G 1 D 5					
ė,	1 an Heal am 2		20a. Method of Disposition 20b. Place of	of Disposi	ANTALLON DR.,	FT. WASH	INGTON MU Oc. Location - City or To	20744
ē	nt of nt of t: If it		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State	ery, crema	atory or other place)		· ·	
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If Itam 27 Is marked any injury or other traumatic e once.		`4 □Donation 5 □Other (Specify) R ⊥ V E R 21. Signature of Euneral Service Licenses			9/04 R	IVERDALE,	MD.
Ba	Depa Depa Impo any i		-houle 10 Bluer	361	Name and Address of Facility B3	LUFURD F	UNERAL SE	
			23a. Part1. Enter the disease, or complications that caused the death. Do					20010
			snock, or near failure. List only one cause on each line.				OCIDENS	Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)		heroscleration	c cosdio	rascular	
	Examiner		Dye to (or as a consequence	ol):				
Mary S		-	Eaguer thany fist curditions, if any, leading to immediate Due to (or as a consequence	of):				
	ned nsit	든	Cause (Disease or injury	J. / .				
	al-tra	Examiner	that initiated events c. Due to (or as a consequence	of):				
8760,	cate be executed physician and the burial-transit	dlcal						
.89	ificate g phy as the	edic	0.					
Вох	the death certific y the attending p Iched for use as	M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Date of delive	0/
m	death a atte	cla	in the past 12 months? 1 Yes 2 No 1 Ves 2 No		Ectopic pregnancy Other (specify)			Day Year
0	that the de sed by the a detached t	Physician/Me	9 Unknown					
٥.	The law requires that ate has been signed bage 2 should be deta	y P	Part II. Other significant conditions contributing to death but not resulting in	n the und	derlying cause given in Part I.	23e. Did toba	cco use contribute to the	e cause of death?
Vital Records,	quires n sign ald be	Completed by	end stage renal dispose			1 ☐ Yes	2□No 3□Proba	ably 4 Unknown
00	w requir	lete	0			24a. Was an	24h Were auton	sy findings available
Be	he lav e has	mc				autopsy	prior to con	pletion of cause of
		Ö	25. Was case referred to medical			1 Yes 2	d? deatb?	2 □ No
	Physician: The this certilicate hi ral director, page	0 8	examiner? War Yes 2 No	utmati ant	3 DOA Other: 4 Nursing H	ath Check only one		
ō	Phys or this oral di	$\vdash \downarrow$		Time of	28c. Injury at	28d. Describe how	6 ☐ Other (Specify, injury occurred))
0	th. : After s funer	읖	1 Xatural 5 ☐ Pending (Month, Day Year) II 2 ☐ Accident investigation	Injury	Work? M 1 ☐ Yes 2 ☐ No		.,.,	
Division of	l or Attending after death. Director; After in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, fa	ırm, stree	at, lactory, office	28l. Location (Stre	et and Number or Rural	Route Number.
Ö	afor A after I Dire d in b	Certification;	4 ☐ Homicide determined building, etc. (Specify)		·	City or Town,	State)	
	To the Hospital or Attending Phymbin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	alc	29a. Certifier 1 Certifying Physician: To the best of my knowledge	e, death c	occurred at the time, date and place	, and due to the caus	se(s) and manner as sta	ted.
	within 24 To the Fu completel	edical	one) 2 XMedical Examiner. On the basis of examination and manner stated.	wor inve	sugation, in my opinion, death occu	irred at the time, date	and place, and due to	the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier		29c. License number		. Date signed (Month, D	
7			Hot I mi - tolle	Lw	OCME	M	ARCH 27, 2	004
0			30 Name and address of person who completed cause of death (Item 23a) ((Type, Pr	rint)			
					nn Street, Balti	more, Mar	yland 21201	
	Sta	_	31. Date liled (Month, Day, Year) 32. Registrar's Signature	/	1 -			
	Registra	ar	MAR 2 9 2004	DEAL.				

	:		For State	Please `		laryland / D		k. Ensure A Health and N	Mental Hygi	ene	
	Physici	ian	1. Decedent's Name	e (First, Middle, Las Ward	t)		Jertificate o	i Death	2. Date of Death Month	Day Yee	3. Time of Death
	/Medic	cal			atmat and available	-1	4h Cib. Tours	art continue of Death	03		
	Examir	ner		If not institution, give			Clinto	, or Location of Death		4c. County of De	
			5. Social Security N	n Maryland		L ge (In yrs. last birth			8. Date of Birth	0.0	George's
	Funeral Director		421-30-5 Usual Residence of	860	☐M 2፟፟፟፟፟፟XIF	80 Y	Months Day		(Month, Day,) 01/14/	1924 A	Country) Labama
	and		10a. State	10b. County		10c. City, Town	or Location				10d. Inside City Limit
	ith the Marylan or 28a-f show e notified at	ō	MD	St. Char	les	Wai	ldorf				XXYes 2 □ N
	28a	Director	10e. Street and Nu	mber			10f. Zip Code)	109	g. Citizen of What	Country?
	138 o	0	2806 De	sert Sun	Court		2	20603	U	nited Sta	ates
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumetic event, I're Medical Exacides rust be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Marr 3 分Widowed	ied 2 Married	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	? INo		f Hispanic Origin? (Sauban, Mexican, Puerto			nerican Indian, nite, etc.
8	hour tural	edt	o igrindomod	15. Decedent's Ed		16a F	Decedent's Usual Occ	upation	16	6b. Kind of Busines	re/Industry
Maryland 21215-0036	vithin 72 ne. han "na e Me ilc	Completed	Elementary/Seco	ondary (0-12)	College (1-4or		Give kind of work don ife. DO NOT use reti Domestic	ne during most of work red)	king	Private	
2	iled v lygie her t	ပိ	12 t	n (First, Middle, Last)			Domesere		ne (First, Middle, Ma	oidea Cumema)	
anc	t be find he of	Be		t Thomps	on Tr			Susanna		alden Sumame)	
Ž	hould d Me mark metic	ပ		ame/Relationship (7		19h 3	Aziling Address /Stm	et and Number or Rui		City or Town State	Zin Cada)
Mar	d 2 s th an th an ty is:			Thompson			-	pe Rd Apt.			gton, DC
	1 an Heal tem 2		20a. Method of Dis	-	,		Disposition (Name of crematory or other p			Oc. Location - City of	<u> </u>
Baltimore,	Pages ment of tent: If it		° 4 □ Donation	☐ Cremation 3 ☐ 5 ☐ Other (Specify)	9 1	o Nationa	$\frac{1}{1}$ 3/19	0/04	Triange,	VA
Ball	Depar Impor any in		21. Signature of Fu	neral Service Licen:	ha M	1		ress of Facility J. dover Rd.			
60,	Medical Examiner Associate and Street and S	Ical Examiner	Immediate Cause disease or condition resulting in death) Sequentially list condition and the cause Enter Under Cause (Disease of that initiated events resulting in death) in the condition of the cause (Disease of the ca	inditions, nmediate orlying urjury S Last	b. Due to (or)	s a consequence of	Dollar Lun	Farlesse	1		24hr 24hr
O. Box 687	that the death certificate to the by the attending physis detached for use as the to	by Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 [9 □ Unknown	months?		e of pregnancy 2 Fetal death at time of death	3 □Ectopic pregnan 5 □ Other (specify)	ісу		23d. Date of d Month	elivery Day Year
S, P.	w requires that the state of speed by should be detact	by Ph	Part II. Other signif	ficant conditions co	ntributing to death	but not resulting in t	he underlying cause g	given in Part I.			to the cause of death?
ord	equit	ted							1 L Yes	2 □ No 3 □ F	Probably 4 XUnknow
ンけ Il Records,	The law requires that the cate has been signed by the page 2 should be detache.	Completed							24a. Was an autopsy performe	id? death?	autopsy findings available completion of cause of s
スク/ Vital	ician: Th certificate rector, pag	Be	25. Was case refer examiner?	/	Hospital:				h (Check only one)		
-30-	Physician: rthis certificanal director,	ြ	1 Yes 2 🗹	INO	1 🗆 Inpati		atient 3 DOA		me 5 Residence		ecify)
Division of	ending Path. or: After he funer	Certification;	27. Manper of Deat 1 Natural 2 Accident	5 Pending investigation	28a. Date of Inj (Month, Da	ury 28b. Tin ay Year) Inju	ıry W	uryat ork? ⊒Yes 2⊡No	28d. Describe how	injury occurred	
X in	al or Att s after d sl Direct od in by t	Sertifle	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of In building, e	njury - At home, farm tc. <i>(Specify)</i>	i, street, factory, office	9	28f. Location (Stree City or Town, S	et and Number or F State)	Ru <i>ral Route Number</i> ,
7	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	ledical (29a. Certifier (Check only one)	1⊠ Certifying Phy 2□ Medical Exam	rsician: To the best iner: On the basis of and manner s	of examination and/	death occurred at the or investigation, in my	time, date and place, opinion, death occur	and due to the caus	se(s) and manner a a and place, and du	as stated. le to the cause(s)
	ro the vithin 2 the comple	Me	29b. Signature and	title of certifier			29c. Licer	nse number	29d	. Date signed (Mor	oth, Day, Year)
	- > - 0		1	1	1		1)_	24535	19	7 77	NU
R	(5)		30. Hame and addr	ess of person who c	~ / ~	1	ype, Print) DR.	LAXMI BURI	WA	M7. 45	20725
	Sta	ate	31. Date filed (Mon			ISNAUCK trar's Signature	7704.	L Mn	NOW ,	1110	(010)

			For State	State of M	aryland / Dep	partment of h	lealth and N	lental Hyg	iene iene 2004	12478
10			Registrar 1. Decedent's Name (First, Middle, Last)			ortinoate or	Douin	2. Date of Deatl		3. Time of Death
	Physici	,	DONALD HARRY WHIT	re				Month MARCH	Day Year 2004	8:45 A ^M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death		4c. County of Dea	
			PRINCE GEORGES HO	SPITAL C	ENTER	CH	EVERLY		PRINCE	GEORGES
	Funeral		5. Social Security Number 6. Sec		e (In yrs. last birthda	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		thplace (State or Foreign
e .	Director		212 34 1162	M ZUF	66 Yrs.			MAR. 29,		ARYLAND
	and		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Manyl f sho	٥.	DC			LIACHTNOTO	ant.			1XXes 2 No
	the 28a-	Director	10e. Street and Number			WASHINGTO	'IN	10	og. Citizen of What C	ountry?
	3a or	Ö	2007 37TH ST. SC	DUTHEAST	#201		20020		IINTTED	STATES
	72 hours after death with the Maryland Insturel', or larns 23s or 28s-1 show Jissi Esanilaer must be rediffed at	Funerai		12. Was Decedent Armed Forces?		. Was Decedent of H		ecify Yes or No-	14. Race - Ami	ericen Indian,
9	after or Ite		1 ☐ Never Married XX Married	XX Yes 2 ☐ If Yes, Give	№ 1958–	1 Yes 2 XX	Specify:	rican, etc.)	Black, Whi	
8	Jural',	d by	3 Widowed 4 Divorced	Year or Dates:	1962				Specify: B]	LACK
5	s within 72 hours after death with the Marylan liene. r than "natural", or flams 23e or 28a-1 show the Medical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad		(Giv	edent's Usual Occup e kind of work done DO NOT use retire	during most of work	ing	16b. Kind of Business	/Industry
12	within ene. than	dmo	Elementary/Secondary (0-12) 12TH	College (1-4or !	5+)	TRUCK DR			PRIVATI	7
9	Hyg the int,		17. Father's Name (First, Middle, Last)		<u> </u>	I KUCK DK	18. Mother's Name	e (First, Middle, M		3
an		To Be	OTIS WHITE				LUCY	(UNKNOWN	()	
Maryland 21215-0036	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Ma	ling Address (Street			City or Town, State,	Zip Code)
	and 2 laith a		GLORIA WHITE / WIE	Æ	2007	37TH ST.	SE #201	WASHI	NGTON, DC	20020
ore	ges 1 and t of Healt if item 2 or other		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ F	lamoval from State	20b. Place of Dis	oosition (Name of ematory or other pla	ce)	Date 2	20c. Location - City or	Town, State
Ë	Pa men ant: ury		'4 Donation 5 Other (Specify)	amoval nom state		LL CEMETE		7,2004	SUITLAND	
Baltimore,	permit. Departmimporta		21. Signature of Funeral Service Licens	өө . () р	0 M	22. Name and Addre	ss of Facility FUNERAL	HOME OF	MARYLAND,	NC.
	40 = 9			ansh		308 SUITL	AND ROAD	$_\SUITL$	AND MD 20	746
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ne cause on each li	the death. Do not e	nter the mode of dyli	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
?	Physician		Immediate Catise (Final disease or condition resulting in death)			SWN				
	/Medical Examiner			Due to (or as	e consequence of):					
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of):)		-		
	uted	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	A	WIF	REWIN	EA	- Cure	6	
ó	te be executed ysicien and e burial-transit	Еха	resulting in death) Last	Due to (or as	a consequence of):		(-/_)		~	
120	A × 6	icai		d						
89	death certificate b e attending physic ed for use as the b	Physician/Medi	IF FEMALE:			-				
Вох	ath ce ttendi or use	an/l	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐Ectopic pregnancy	,		23d. Date of de Month	ivery Day Year
0.	0 00 0	/sic	1 Yes 2 No	4□ Pregnant at 9□ Unknown	time of death 5	Other (specify)			No.	Day
<u>α</u> .	law requires that the das been signed by the 2 should be detached	Ph	Part II. Other significant conditions cor	ntributing to death b	ut not resulting in the	underlying cause giv	en in Part !	23e. Did tob	acco use contribute to	the cause of death?
ds,	signe d be	d by		,		yg g				obably XXUnknown
Ö	w requir been si should	ete						24a. Was an		
Re	9 - 9	Completed						autopsy perform	prior to	itopsy findings available completion of cause of
of Vital Records,	an: Th tificate tor. pag	e Co	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes X	21	2 □ No
>	Physician: this certific ral director.	To B		lospital:XX Inpatie	ent 2 ER/Outpati	ent 3 DOA Oth	ar		nce 6 Other (Spe	city)
10	g Phy er thi		27. Manner of Death	28a. Date of Inju	ry 28b. Time	of 28c. Injur		28d. Describe how		on y)
jo	Attending ir death. actor: After by the fune	atio	XX Natural 5 Pending 2 Accident investigation	(MONIII, Da	, roas, injury		Yes 2 □ No			
Division	ul or Attending P after death. I Diractor: After t d in by the funera	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, farm, s	treet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ıral Route Number,
	ital or irs afte ral Dir						ı			
	Hospital 24 hours 2 Funeral I	edical	Check only 2 Medical Exami	ner: On the basis o	examination and/or	ath occurred at the tir investigation, in my o	ne, date and place, pinion, death occur	and due to the car ed at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the Hospital or At within 24 hours after of To the Funeral Diract completely filled in by	Med	one) 29b. Signature and title of certifier	and manner st	100.	29c, Licens			d. Date signed (Mont	
	F 3 F 8		101.001	a		72	2 (1	3/22/21	/
)	(10)		30. Name and address of person who co	ompleted cause of o	eath (Item 23a) /Type	Print)	13/1	0	122/08	2
	(1)		OPHNEL CUMBERBATO		outer (nom zoa) (19pi		OSPITAL D	RIVE CH	EVERLY, MD	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature		D.	VII	TID e LIVIE	
	Registr	ar	MAR 2 9 2004	Deser	A Apo	a constant				

			- For	State of Marylar				•	iene	101 -
			1 - State Registrar	.,	Ce	rtificate of	Death	Re	_{19. No.} 200	+ 12479
	Physici	an	Decedent's Name (First, Middle, Last	9				2. Date of Deat Month	h Day Year	3. Time of Death
4	/Medic	al	George F. Wahaus 4a. Facility Name (If not institution, give			4h Cib. Town	or Location of Death	March 29	9, 2004 4c. County of Dea	7:00 P M
#	Examin	er	Wilson Health Car			Gaither			Montgom	
	Funeral		Social Security Number	x 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		rthplace (State or Foreign ountry)
ı,	Director		214-03-3612	XIM 2□F 98	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, March 3,	1906 Ma	ryland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	Maryl	tor	Maryland Montgome		otomac					1 ☐ Yes 25 No
	r 28a	rec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	th wit	Funeral Director	10724 Rock Run Dri	ve		2085	54	τ	Inited Sta	tes
	tems tems	nuel	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
36	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	177 Yes 2□NoWorl If Yes, Give Year or Dates: War	.d	1 ☐ Yes 21 No	Specify:		Specify: V	Vhite
9	2 hou atura cal E	ted	15. Decedent's Edu	ucation		dent's Usual Occup	pation during most of work		16b. Kind of Business	VIndustry
215	thin 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	NOT use retire	during most of world)	ring	United St	ates
2	ygien ygien her th	Con	12	_	Carto	ographer	T		Governmen	t
and	ould be filed within 72 hours after death with the Maryland Menial Hygiene. arked other than "natural", or Items 23a or 28a-f show atte event, the Medical Evanthar must be notified at	Be	17. Father's Name (First, Middle, Last) Unknown					e (First, Middle, N	faiden Sumame)	
Maryland 21215-0036	should nd Me mark matic	ဥ	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailir	ng Address (Street	Unknows		City or Town, State,	Zip Code)
<u>8</u>	alth ar 27 is rr trau		Henry Kumm, Jr./ F:						Maryland	
Jre,	of Her	1 5	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ F	20b. F	Place of Disease	sition (Name of matory or other pla omery_			Oc. Location - City or	
Ĕ	Pag ment ant: I		'4 □ Donation 5 □ Other (Specify)	Cr	emaror	llim. Inc.	2004	В	ethesda, l	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene when the shown Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any july or other traumatic event, the Medical Evanthar must be notified at once.		21. Signature of Funeral Service Licens	M00689	Ro	Name and Address Ckville, Rockv	iss of Facility No. Inc. 300 ille, Man	ert A. P West Mo Vland 20	umphrey Funtgomery A 850-1805	uneral Home/ Avenue,
Б			23a. Part Enfer the disease, or compi shock or heart failure. List only or	lications that caused the deat ne cause on each line.	th. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory arre		Approximate Interval Between
>	Physician		Immediate Cause (Final disease or condition resulting in death)	· Pneum	ones	a (File	iteral)			Omeet and Death
盤.	/Medical Examiner		Tosularing in dealiny	Due to (or as a consec						1
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	quence of).			- 11 -/-		
	outed Id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
760,	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a conseq	quence of):					
6876	icate be executed physician and s the burial-transit	dical		d						
9 X O	death certificate I a attending physi of for use as the b	/Me	IF FEMALE:	23c. If yes, outcome of pregna	ancv				23d. Date of de	h
ñ	death a atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	al death 3	Ectopic pregnancy Other (specify)	у		Month Month	Day Year
0	that the de ed by the detached	hys	9 Unknown	9□ Unknown						
	S C B	Completed by Physician/Med	Part II. Other significant conditions con	ntributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tob		the cause of death?
ord	w require been sig should b	ted	Dysphagile.	reprova	beis	- 5		1 Yes	s 2 ∰No 3 ∏ Pi	robably 4 Unknown
Vital Records,	has b	mple	Kennet Ce	reference	Acce	(de a	cident	24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
a		e Co	Derrenter					1 ☐ Yes 2	ØNo 1□Yes	2 □ No
		To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outnatien	t 3C DOA Ott		h Check only one	nce 6 Other (Spe	aif.
0	ਦ ≑ ਛ		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of			28d. Describe hov		ony)
<u>S</u>	r Attending P ter death. irector: After i by the funera	catic	2 ☐ Accident investigation				Yes 2 □ No			
Division of	0 # 0 =	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str fy)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
_	To the Hospital within 24 hours of To the Funeral of completely filled		29a. Certifier 1 - Certifying Phys	sicien: To the best of my kno	owledge, death	occurred at the tir	me date and place	and due to the car	use(s) and manner as	stated
	ne Ho n 24 h ne Fui	edical	(Check only 2 Medical Exami one)	iner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my o	pinion, death occur	red at the time, da	te and place, and due	to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	ø	í.	29c. Licens			d. Date signed (Mont	
	C11		> HPrheets	zzzeber	1125	0	204115	12	Tarch 2	9,2004
	7		30. Name and address of person who co	Impleted cause of death (Item	7 (Type.	Print), 201	PUSSE	LL AVE	he.	0877
-	Sta Registr		31. Date liled (Month, Day, Year) APR 0 2 200	32. Begistrar's Signa	attire &	Sparks				

			1 - For State Registrar	State of M	laryland / De		of Health	n and M	lental Hyg	_		12480
	Physic	ian	Decedent's Name (First, Middle, L						Date of Death Month	Day	Year	3. Time of Death
5	/Medi		Randolph Emi 4a. Facility Name (If not institution, g.		-)	4h City To	own, or Location	on of Death	March 3	4c. Count		12:17 am
	Exami	ner	8505 Spring		,		er Spri				tgome	* 3.7
	Funeral			Sex 7. A	ge (In yrs. last birthda	y) If Under 1		ler 24 Hrs.	8. Date of Birth			lace (State or Foreign try)
	Director		578-52-1946 Usual Residence of Decedent	1 ⊠ M 2□F	98 Yrs.		Days Hour	S MIN.	Mar. 2,	1906	Ind	iana
	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic svent, the Medical Exeminar must be notified at	ctor	Maryland Mont	gomery	10c. City, Town or Silve	Location r Sprin	ng				1	0d. Inside City Limits 1 ☐ Yes 2 🐴No
	or 28	Funeral Director	10e. Street and Number			10f. Zip C	ode		10	g. Citizen of	What Coun	try?
	s 23s	ra	8505 Springvale				20910			US		
10	ter de	Fune	11. Marital Status 1 □ Never Married 2 【X Married	12. Was Deceden Armed Forces 1 2 Yes 2	?	If Yes, specif	nt of Hispanic (y Cuban, Mexic	Origin? (Spe can, Puerto i	ecify Yes or No- Rican, etc.)		ce - Americ ck, White,	
21215-0036	al', ou	by	3 □Widowed 4 □Divorced	If Yes Give	1928-58	1 ☐ Yes 2	No Speci	ify:		Specia	y:Whit	e
2-0	72 ho	Completed	15. Decedent's I (Specify only highest g	ducation	16a. De	pedent's Usual	Occupation	act of working	1	6b. Kind of B	usiness/Ind	lustry
21	ithin ne.	dr	Elementary/Secondary (0-12)	College (1-4or	5+)	ve kind of work . DO NOT use	retired)	IOSI OI WOIKII	, g			
22	2 should be filed within n and Mental Hygiene. Is marked other than "raumatic svent, the Men		12 17. Father's Name (First, Middle, Las	f)	Mı	ısician	10 Ma	About Norman		U.S. A		and
Maryland	d be f	Be c	Andrew Harry						(First, Middle, M th Kathe		,	
7	should nd Me mark imatic	2	19a. Informant's Name/Relationship		19b. Ma	ilina Address (I Route Number,			Codel
M	and 2:		Elizabeth Ann Wa									MD 20910
ore,	of Hear Item		20a. Method of Disposition	7	20b. Place of Dis	position (Name	of	D	ate 2	Oc. Location		
Ē	nit. Page partment or cortant: If injury or injury or		1 Burial 2 ☐ Cremation 3 1 Donation 5 ☐ Other (Spec		Gate_OI	Heáven eterv	5. 5.250)	Apri 20		Silver	Spri	ng MD
Baltimore,	permit. Pages 'Department of Himportant: If ite any injury or ot once.		21. Signatur o Funeral Service Lice	I Cole		22. Name and Francis	Address of Fac	llins	Funeral	Home	[nc	2, MD 20901
8760,	Live be executed / Medical Examiner buysician and substitution in the purish transit substitution is the purish transit substitution in the purish transit substitution is the purish transit substitution in the purish transit substitution is the purish transit substitution in the purish transit substitution is the purish transit substitution in the purish transit substitution is the purish transit substitution in the purish transit substitution is the purish transit substitution in the purish transit substitution is the purish transit substitution in the purish transit substitution is the purish transit substitution in the purish transit substitution is the purish transit substitution is the purish transit substitution in the purish transit substitution is the purish transit substitution in the purish transit substitution is the purish transit substitution in the purish transit substitution is the purish transit substitution in the purish transit substitution is the purish transit substitution in the purish transit substitution is the purish transit substitution in the purish transit substitution is the purish transit substitution in the purish transit substitution is the purish transit substitution in the purish transit substitution is the purish transit substitution in the purish transit substitution is the purish transit substitution in the purish transit substitution is the purish transit substitution in the purish transit substitution is the purish transit substitution in the purish transit substitution in the purish transit substitution is the purish transit substitution in the purish transit substitution is the purish transit substitution in the purish transit substitution is the purish transit substitution in the purish transit substitution in the purish transit substitution in the purish transit substitution in the purish transit substitution in the purish transit substitution in the purish transit substitution in the purish transit substitution in the purish transit substitution in the purish transit s	ilcal Examiner	23a. Part1. Enter the disease, or cor shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Conges Due to (or a: b. Hypert Due to (or a:	tive Heart s a consequence of): ension s a consequence of): a consequence of):			as cardiac o	respiratory arre:	st,		Approximate Interval Between Onset and Death 2 Years
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic preg					te of deliver	y Day Year
	res that igned b	by Pi	Part II. Other significant conditions	contributing to death	out not resulting in the	underlying cau	se given in Par	t I.	23e. Did toba	cco use cont	ribute to the	e cause of death?
rd	w require been sig should b	pa	Chronic Obstruct	ive Pulmo	nary Disea	se,			1 ☐ Yes	2 🗆 No	3 ☐ Proba	ıbly 4. ⚠Unknown
of Vital Records,	e law re has be je 2 sho	Completed	Angina, Anemia						24a. Was an autopsy			sy findings available
<u>=</u>		Con							performe 1 ☐ Yes 21	ed?	death?	
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				ce of Death	(Check only one)			
of	Phys this al dii	2	1 Yes 2 No 27. Manner of Death	1 L Inpati	ent 2 ER/Outpati				ne SKA Residen			1
on	ding h. After fune	tlon	1 ☑Natural 5 ☐ Pending	28a. Date of Inji (Month, Da	iry Year) 28b. Time Injury	M 280	Injury at Work? 1 ☐ Yes 2 [8d. Describe how	' injury occuri	ed	
Division	or Attending after death. Director: After I in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not to determined	28e. Place of In	jury - At home, farm, s tc. (Specify)				8f. Location (Stre City or Town,	et and Numb State)	er or Rural	Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysician: To the best miner: On the basis of and manner st	of my knowledge, dea of examination and/or ated.	th occurred at nvestigation, in	the time, date a my opinion, de	and place, as eath occurre	nd due to the cau d at the time, date	se(s) and ma	nner as sta and due to t	ted. the cause(s)
		Me	29b. Signature and title of certifier	A. A			icense number		290	l. Date signed	(Month, D	ay, Year)
	4) -1 -w	7 /w 1		DC	17	146		Apr	i 1 2,	2004
	V		30. Name and address of person who									
	Cto	†a	Jeffrey Mazique 31. Date filed (Month, Day, Year)		25 16th St rar's Signature			hingto	on, DC 20	0307		
i i	Sta Registr		asp 0.2 2		ar 3 digriature g	space	KI					

Brandt E. Weiss Unknown 04-097 04-2142

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ι	oos		1 - For State Registrar	State of Maryland / Dep	eartment of Health and I ertificate of Death		giene neg. n2 0 0 4	12481
	Physic	ian	Decedent's Name (First, Middle, Las	,		2. Date of Dea Month		3. Time of Death
. >	/Medi	cal	BRANDT EDWARD M 4a. Facility Name (If not institution, give		4h City Town and acadian of Durat		28 2004	345 a ^M
	Exami	ner	219 Ednor Road	street and number)	4b. City, Town, or Location of Death Sandy Springs	1	4c. County of Dea	
	Funeral	11	Social Security Number 6. Se		If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day	Montgome 9. Bir	CTY thplace (State or Foreign ountry)
	Director		223-27-2206	X M 2□ F 21 Yrs.	Months Days Hours Min.	July 27		irginia
	and		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	Maryl faho inda	ō						1 Yes 2 No
	28a	Director	Virginia Fairfax 10e. Street and Number	Vienna	10f. Zip Code	1	log. Citizen of What Co	
	h with	a D	1721 Wind Haven Wa	av	22182		USA	,
	ems erm	Funeral	11. Marital Status		Was Decedent of Hispanic Origin? (St If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame Black, Whit	
36	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examination must be notified at once.	by FL	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:		Specify:	White
Maryland 21215-0036	2 hour	edit	15. Decedent's Edu	Year or Dates: 16a. Dece	edent's Usual Occupation		16b. Kind of Business.	
215	hin 73 Bu na	Completed	(Specify only highest grad Elementary/Secondary (0-12)	de completed) (Give life.	a kind of work done during most of wor DO NOT use retired)	king	College -	- George
21	ed wit	Con			ıdent		Mason Univ	rersity
Ind	tal Hydral Hydral even	Be	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, I	Maiden Sumame)	
3	d Men d Men narke	2	Dennis N. Weiss		Pamela			
Ma	d 2 sl th and t7 ls n traun		19a. Informant's Name/Relationship (T) Pamela Hauck Weiss		ing Address (Street and Number or Ru. Wind Haven Way, V			Zip Code)
ē,	Heal Heal	1 3	20a. Method of Disposition	20b. Place of Disp	osition (Name of	_	20c. Location - City or	Town, State
E	Peges ento nt: If i		1 ☐ Burial 2 ☑ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	TOTAL TOTAL STATE	matory or other place) Litan Crematory 4/0			
Baltimore,	partm porta y inju		21. Signatura Funeral Service Licens		2 Name and Address of Facility		lexandria,	Virginia
<u>m</u>	88 5 8		May Da	Med	MONEY & KING F 171 W. Maple A	UNERAL H	OME, INC.	2180
			23a. Part1. Enter the disease, or composition of heart failure. List only o	lications that caused the death. Do not en ne cause on each line.	ter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
7	Physician		Immediate Cause (Final disease or condition resulting in death)	MULTIPLE TAYOU	1			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
		er	Sequentially list conditions,	b. Due to (or as a consequence of):				
	uted d ansit	Examin	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events					
o,	en an	Еха	resulting in death) Last	Due to (or as a consequence of):				
68760,	ficate be executed physicien and is the burial-transit	edical		d				
	ertific ling p		IF FEMALE:					
Вох	The law requires that the death certificate has been signed by the attending to agge 2 should be detached for use as	Physician/M	in the past 12 months?		Ectopic pregnancy		23d. Date of deli Month	very Day Year
P.O.	that the de led by the a detached	nysic	1 Ves 2 No 9 Unknown	4☐ Pregnant at time of death 5 [9☐ Unknown	Other (specify)			,
	s that ned b e deta	by Pł	Part II. Other significant conditions con	ntributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rds	w requires been sign should be					1 ☐ Ye	s 2. No 3 □ Pro	obably 4 Unknown
900	e law requ has been je 2 shoul	Completed				24a. Was an		topsy findings available
H		Com				perform 1 Yes 2	ned? death?	ompletion of cause of 2 No
of Vital Records,	Physician: 1 this certificated director, p	Be (25. Was case referred to medical examiner?		26. Place of Deat			
of	Phys this al dii	2	1 XYes 2 No 27. Manner of Death	lospital: 1 Inpatient 2 ER/Outpatier 28a. Date of Injury 28b. Time o				ify) at scene
O	iding Phy th. : After thi funeral	Certification;	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 3 - 24 - 04 0 3 3 0	Work?	28d. Describe how	winjury occurred	44
Division	or Attendater deat Director: in by the	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm, str	-		eet and Number or Rui	
Ö	s afte	Sert	4 Homicide	building, etc. (Specify)		City or Town,	State)	
	t hour uner	edical	29a. Certifier 1 ☐ Certifying Physic (Check only 2 ☐ Medicel Examination Check only 2 ☐ Medicel Examination Check only 2 ☐ Certifying Physics (Check only 2	sician: To the best of my knowledge, death	occurred at the time, date and place	and due to the co-	uso(s) and masses as	atata d
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medi		and manner stated.				
	5 × 5 × 5	~	29b. Signature and title of certifier	1/ 1/1 2	29c. License number OCME		d. Date signed (Month) Iarch 28 20	
7	7		mulline hel	finill M)		1,1	LOT C11 20 20	V -1
			30. Name and addr s of person who co	mpleted cause of death (Item 23a) (Type,	111 Penn Street	, Baltim	ore, Maryl	and 21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature				

Registrar DRIVIE 17 Hev 1/2001

State

Sparker

32. Registrar's Signature

MAR 31 2004

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 4 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Dev Physician Carolee Wilson March 23, 2004 9:00 PM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Locetion of Death Examiner 4c. County of Death Holy Cross Nursing & Rehab Burtonsville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) June 10, 1 6 Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□ M 2√ F 94 187-20-1722 Yrs. Director 1909 Georgia Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours efter death with the Marylend ment of Health end Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examinar must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 √ Yes 2 No Director Maryland| Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 10000 Brunswick Ave. Apt. 307 20910 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ᡚ No
If Yes, Give
Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: **Black** 2 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Yrs. Registered Nurse Healthcare 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Freeman Jefferson Virginia Calloway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Homer Wilson- Son 1111-B McNeil Ln. Silver Spring, MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If It any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenwood Cemetery 04/02/04Pittsburg, PA 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityHines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, MD 20904 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Hypertension Examiner Due to (or as a consequence of): Physician/Medical Examiner General Debility anding physicien end use es the bunel-trensit or Attanding Physician: The lew requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Anemia Due to (or as a consequence of): Dehydration 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yes <u>ک</u> Completed 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was en autopsy performed? 2 DKN0 1 Tes 1 ☐ Yes 2 ☐ No within 24 hours efter deeth.

To the Funeral Diractor: After this certifica completely filled in by the funeral director, 8 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1□ Yes 2⊅No 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ima Khan D00058965 March 25, 2004 30. Name end address of person who completed cause of death (Item 33a) (Type, Print) Saima Khawaja, M.D. 11119 Rockville Pike Suite 100 Rockville, MD 20852

Registrar DHMH 16 Rev 6/95

State

31. Date filed (Month, Day, Year)

MAR 3 0

32. Registrer's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. O. I

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3. Ti	me d	of De	ath	
8.	40	1 4	м	

Division of Vital Records P.O.

			Stat	e of Maryla	na / De C	ertificate d	n nealth and of Death	ivientai my	/gierie 2 (004	1241	83
	Physici	an	Decedent's Name (First, Middle, Last) The second March Charles and Line Charles and L					2. Date of D	eeth 26, Dey 2004	, Yeer	3. Time of Dea	
	/Medic	al	James McSherry Wimsat 4e Fecility Neme (If not institution, give street er				4h City Town o	March r Location of Dea		y of Deeth	8:40 A	М
	Examin	er	25 W. Irving Street	io namoon,			Chevy Cl			gomery		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs		Months Da	ar If Under 24 Hr	s. 8. Date of Bi	irth	9. Birthpla	ace (State or For	reign
	Director		578-01-3709	91	Yrs			Nov. 2	23, 1912	Washi	ington,	DC_
	ylend wor		10a. Stete 10b. County	10c. C	City, Town or	Location				10	d. Inside City Lin	mits
	e Mer	ctor	Maryland Montgomery	Ch	evy C	hase					12⊈ Yes 2□] No
	Vith the	Dire	10e. Street end Number			10f. Zip Coo			10g. Citizen of		•	
	m 234	Funeral Director	25 W. Irving Street 11. Marital Status 12. Was	Decedent Ever in	U.S. 1			Specify Yes or N	United	ce - America		
0050	permit. Pagas 1 and 2 should be filed within 72 hours efter death with the Meryland Deperturant of Heatile and Mentall Hygiene. Deperment of Heatile and Mentall Hygiene. Important: If then 27 is marked other than "naturel", or terms 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	5	1 Never Married 2 Married 1 H	ed Forces? Yes 21 No es, Give r or Dates:		If Yes, specify 0	of Hispanic Origin? (cuban, Mexican, Pue No <i>Specify:</i>	erto Rican, etc.)	Speci	ick, White, e	tc.	
5	72 hor	eted	15. Decedent's Education (Specify only highest grade comple	eted)	16e. De	cedent's Usual Oc	cupation one during most of w tired)	orkina	16b. Kind of E	susiness/Ind	ustry	
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all a	Mental Mental Med of Mic ev	To Be	William Kurtz Wimsatt				Bertha	a McSheri	ry			
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e L	Health m 27		Margaret S. Wimsatt/ V			W. Irving	Street,		nase, Ma			
Daltillo	mant of Hant: If Ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State	Monts emato	gomery gomery rium, Inc	piece)	March 31, 2004	Bethesd	la, Man	ryland	
0	Dependent Dependent Important in Bucan		21. Signature of Funeral Service Licensee	M006	89	Bethes	dress of Facility Ro Chevy Cha da, Maryl	and 2081	L4-3501	y Fund iscon	∍ral Hon sin Aver	ne/ nue,
380	100		23a. Pert in the disease, or complications shock or heart ailure. List only one cause	that caused the dea	ath. Do not	enter the mode of	dying, such es cardi	ac or respiratory a	arrest,		Approximate Interval Between	1
3	Physician /Medical		Immediate Cause (Final								Onset and Death	1
	Examiner		disease or condition resulting in death) e. Ren	nal Failu		sequence of):				1		
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	tificate be axecuted g physician and as the burial-transit	edical Examiner	0			sequence of):						
00100	Sician Duria	a E	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initeted events Due to (or as a consequence of):									
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	ie dea the att hed fo	Physician/	Part II. Other significent conditions contributing	to death but not re	sulting in the	e underlying cause	given in Part I.	23b. Did	tobacco use co	ntribute to	the cause of de	ath?
	that the ed by datac		Generalized Artherios	clerosis				1 🗆	Yes 2 No	3 ☐ Proba	ıbiy 4X Unkr	nown
60.00	To the Hospital or Attending Physician: The law requiras that the death cert within 24 hours state death within 25 cours state death. To the Euneria Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be datached for use.	Completed by							s an autopsy ormed?	avai	re autopsy findin lable prior to apletion of cause eath?	-
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5	ital or At irs after o rei Direct lad in by	Certification:	3 ☐ Suicide 4 ☐ Homicide Signature of Dispute Number of Rural Route Number, farm, street, factory, office building, etc. (Specify) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
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	within To the compl	Me	29b. Signature and title of certifier	n)		ense number		29d. Date signe			
	20		a Jebs lunde	- nk		D	11027		March	26, 20	04	
			30. Name and address of person who completed John B. Umhau, M.D. 88				Chevy Ch	ase, Mar	yland 2	0815		
	Sta Registr		31. Dete filed (Month, Day, Year) MAR 3 0 2004	32. Registrer's Sign	nature 4	Span	61					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** APRIL 2004 10:22AMM MARGARET WEEMS WALKER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner TALBOT EASTON 314 SPRING DRIVE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year SEPT 24 1924 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🗓 F Yrs 79 MARYLAND Director 218-12-1064 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show event, the Mudical Examiner must be notified at 1X Yes 2 □ No Directo TALBOT EASTON MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 314 SPRING DRIVE 21601 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: WHITE þ 3 X Widowed 4 ☐ Divorced "netural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "ne eny injury or other traumatic event, Its Mustic once." Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 EDMUND LEE WEEMS IDA ELIZABETH STIERTZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22349 COOPER LANE WITTMAN, MD 21676 DAVID W. WALKER/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 4-6-2004 STEVENSVILLE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 JOHN R. MERCEROM 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Tobable Cardiovascular dissus **Physician** arterioscleratio /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed and Due to (or as a consequence of): use as the burial-P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 TFetal death jo in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à Pe 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? certificate 2 No 1 Yes To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by I 4 Homicide pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and sille 29c. License number 29d. Date signed (Month, Day, Year) 120044287 ess of person who complete 30. Name and ad XRIRD MA 4410 31. Date filed (Month, Day, Year) APR 0 6 20 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month 0.3 2004 Myrtle White 8:45 p.m. /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Caroline Nursing Home Denton Caroline If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Dale of Birth (Month, Day, Yeer) **Funeral** Birthplace (State or Foreign Country) Months Deys Min. Hours 1□ M 2□F 87 Yrs Director unk 06 28 1916 Maryland Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Haatth and Mantel Hygiene. Important: If Item 27 is marked other than "naturel", or items 23a or 23a-f show any injury or other traumetic event, the Medical Exerciper must be notified at 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Oueen Anne Director Md. Chester 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21619 Funeral 135 Edgewood Road U.S. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ∰ No If Yes, Give Year or Dates: 1 Never Merried 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 @ No Specify: Specify: BLack. þ 3 Widowed 4 Divorced Be Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. QO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Seatord 5-th O Has 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Coleburn Coleburn George Pearl 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 135 Edgewood Rd Chester, Md 21619 Alice P. Williams (daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 18/04 Marrison ChurchCom 21. Signature of Funeral Service Lice 22. Name and Address of Facility Eric L. Dashiell Funeral Service 319 E. Dover St. Easton, Md21601 ain 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediete Cause (Final disease or condition resulting in deeth) /Medical Phenonococcas JEEKS Examiner Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law raquiras that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for usa es the burie Due to (or es e consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No þ 8 24b. Were eutopsy findings available prior to Completed 24a. Wes en eutopsy performed? completion of cause of death? cartificata has b lirector, paga 2 s 1 Yes 2 No 25. Wes cese referred to medical examiner? edical Certification: To Be 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: s after deeth.

I Director: After this cond in by the funerel director. 1 Yes 2√ No 2 ER/Outpetient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral DI completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0053094 who completed cause of death (Item 23e) (Type, Print) EINBOUD, WD Broguingon 321 32. Registrer's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004

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HRLEN WHITE Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

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ner	29704 AMA			umber)			or Location of Dea ASTON	th	4c. (4c. County of Death TALBOT			
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70	HARRY KING		(Tune Dri-1)		105 11			RED GIL					
1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S. STOCKTON WHITE/HUSBAND 29704 AMANDA WAY FASTON, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State												
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111	*4 Donation 5 0			СПВ		E CREMATI		-6-2004	STE	VENSVIL	LR, MD		
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 23a Part 1 Filter the disease or complications that caused the death Do not extent the mark of the												
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DHMH 17 Rev 1/2001

			For State Registrer	State of Maryland		artment <i>tificate</i>			Mental Hy	giene Reg. No.	5007	12487
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Rhonda Renee	e Weeks					2. Date of De Month April	8, Day	004 Year	3. Time of Death 12:38 A ^M
	Examin	er	4a. Facility Name (If not institution, give s 12484 Turtle Dove 5. Social Security Number 6. Sex	Place	ast hirthday)		1dorf	Under 24 Hrs			Charles	place (State or Foreign
L	Funeral Director		579-92-9453 Usual Residence of Decedent	IM 2♥F 41	Yrs.	Months		lours Min		y, Year)	West	Virginia
	he Marylan 8e-f show otified at	ector	10a. State 10b. County Maryland Charles		dorf					10. 611		10d. Inside City Limits 1 Yes 2X No
0036	nit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland arment of Health and Mental Hygiene. ortent: If item 27 is marked other than "neturel", or items 23e or 28e-f show injury or other treumstic event, in Medical Examinar must be notified at a.g	d by Funeral Directo	10e. Street and Number 12484 Turtle Dove 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Place 12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 N No If Yes, Give Year or Dates:		f Yes, specif	2 nt of Hispa y Cuban, M	Mexican, Pue	Specify Yes or No to Rican, etc.)	Unit		es can Indian, etc.
21215-0036	within 72 h ene. than "netu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	tent's Usual kind of work DO NOT use Secre	done dunin retired)	n ng most of wo	orking		of Business/In	dustry
land 5	uld be filled fental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last) Carroll Lee Sandio	ie	Legal	Secre	18.		me (First, Middle Morris			
, Maryland	and 2 should I ealth and Men m 27 is marke her treumatic		19a. Informant's Name/Relationship (Ty) Phyliss M. Normandi	n-mother	12484	Turt	le Do		ural Route Numb	orf.	MD 2060	2
altimore,	permit. Peges 1 Department of H Importent: If ite any injury or ott		20a. Method of Disposition 1	Tri		emoria	al Gdi		Date 12-2004		ation-City or To	-0
■ Bal	permi Depa impo any ii		21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complishock, or heart failure. List only or	MUUU53 cations that caused the death	P.	0. Bo	ox 15		dorf, ML)4	Approximate
8760,	death certificate be executed The discontinuous physician and and and and and and and and and a	lical Examiner		Interval Between Onset and Death								
.O. Box 6	ne death certif the attending thed for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic prec Other (spec				23	ld. Date of delive	ery Day Year
<u>α</u>	quires that the signed by all be detacted	by	Part II. Other significent conditions con	stributing to death but not resu	ulting in the ur	nderlying cau	ise given in	Part I.	_	obacco use		he cause of death?
Division of Vital Records,	The law requires that sate has been signed b page 2 should be deta	Completed).						24a. Was auto perfo 1 ☐ Yes		24b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of
Vita Vita	sicien: Th certificate irector, pag	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	FD/O-1		Othon		ath (Check only o		TO: 10	
ion of	Attending Physicien: r death. ector: After this certific by the funeral director,	ation: To	1 Yes 25 No	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		. Injury at Work?	4 □ Nursing I	28d. Describe		Other (Specificoccurred	y)
Divis	in Dig	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	et, factory,	office		28f. Location (. City or Tou		Number or Rura	al Route Number,
	he Hospitel n 24 hours a he Funerel I pletely filled	edical	29a. Certifier 1 € Certifying Phys (Check only 2 Medicel Examin	sicien: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at restigation, in	the time, d my opinio	late and place on, death occ	e, and due to the urred at the time,	cause(s) a date and p	nd manner as s lace, and due to	tated. the cause(s)
	To the i	Σ	29b. Signature and title of certifier	eo n	20	29c. 1	License nui	9 0 L	142	29d. Date	signed (Month,	Dey, Year)
P	18		30. Name and address of person who co Dr. Charles R. Boi				, Sui	te 205	, Silver	Spri	ng, MD	20902
	Sta Registr		31. Date filed (Month, Day, Yeer)	32. Registrar's Signat		forest.	,					

		1- State of Maryland / Department of Health at Certificate of Death	nd Menta		eneZ () () (,	12488				
Dhysis		1. Decedent's Name (First, Middle, Last)		te of Death	_	3. Time of Death				
Physic /Medi		Helen Virginia Ward	Ma		20 2004	8:30 A M				
Exami	ner	4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of			4c. County of Death					
		5318 Mt. Briar Road Keedysville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2		15:::	Washi					
Funeral Director		232-62-7577 1 M 2 X F 68 Yrs. Months Days Hours		onth, Day, Y	1935 West	olece (State or Foreign otry) Virginia				
ryland how		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		-		Od. Inside City Limits				
e Ma	Director	Maryland Washington Keedysville				1 ☐ Yes 2X No				
ith th	Dire	10e. Street and Number 10f. Zip Code		10g	. Citizen of What Cour	ntry?				
a 23a	B	5318 Mt. Briar Road 21756			USA					
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or Itema 23e or 28e-1 show aumatic event, the Medical Examinat must be rediffed at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2\(\) No 1 Yes, Give Year or Dates:	in? (Specify Ye Puerto Rican, (s or No- etc.)	14. Race - Americ Black, White, Specify:	etc.				
5-0036 72 hours at naturel; or alcal Exem	ted	15. Decedent's Education 16a. Decedent's Usual Occupation		16	b. Kind of Business/In-	hite dustry				
vithin 72 sene.	pje	(Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	of working		b. Kind of Business/Industry					
d 21 filed wi Hygien other th	Completed	7 Housewife			Hoi	ne				
traiting out	Be	17. Father's Name (First, Middle, Last) 18. Mother's	s Name (First,	Middle, Ma.	iden Sumame)					
aryla should ind Men marke umatic	2	Thomas Estes Vandevender Ella		Calh						
> -E ~ E		19a. Informant's Name/Relationship (Type, Print) James H. Ward - Husband 5318 Mt. Brian Road								
C = 01 L		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	-	e , Mary I and c. Location - City or To	21756				
		1 ABurial 2 Cremation 3 Removal from State	04.0		,					
Baltimo		1 dir view cemerery	ar.24,20	004 Ke	eedysville	Maryland				
m Fares		21. Signatur of Funeral Service Licens 22. Name and Address of Facility. Sborne Funeral H	Home,P., ague St	A. "Willi	iamsport.MC	21795				
÷ (6)		23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.	ardiac or respira	atory arrest,		Approximate Interval Between				
Physician		Immediate Cause (Final disease or condition resulting in death) a. Arterior clerote Cordioval	CIO	Onset and Death						
/Medical Examiner		resulting in death) Due to (or as a consequence of):	s (4/LF	ac	CSE S	100				
LAdiiiiiei	_	Sequentially list conditions,								
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68760, ficate be executed physician and is the burial-transit										
tifficat ng phy as th	ledical									
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he death the death the atte	hysician/M	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)			Month	Day Year				
P.C.	Phy	3 - Olikilowii								
COTGS, P.O. w requires that the de been signed by the s should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e	_	co use contribute to the					
COLDS W requires been sign should be	etec	Did No III	- 14-	1 🗆 Yes		ibly 4 Unknown				
The la	Completed	Diaseter Hole Color Cype II		. Was an autopsy performed Yes 2 🔀	? prior to con	sy findings available apletion of cause of 2 No				
OT VITAL IN Physicien: The This certificate ral director, pag	Be	Hospital:	Death (Check							
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JIVISION I or Attending after death. Director: Ate	tion	27. Manner of Death 1		CIDO HOW II	nuly occurred					
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tal or s afte	Certification:	4 ☐ Homicide building, etc. (Specify)	City	or Town, St	ate)					
UIVISION O To the Hospital or Attending PP within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and p and manner stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and p and manner stated.	place, and due to occurred at the	to the cause time, date :	e(s) and manner as sta and place, and due to	ted. the cause(s)				
To t Withi To t	Σ	29b. Signature and title of certifier 29c. License number		29d.	Date signed (Month, D	ay, Year)				
N		02680	16	N	Varch 22	2004				
5H'		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	/		2					
		31. Date filed (Month, Day, Year) 32. Registrar's Signature	foun	VW) 2174	2				
Sta Registr		31. Date filed (Month, Day, Year) AR 2 2 2004 32. Registrar's Signature								
	274									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 L Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 17, 11:39AM Violet Jessica Werres March 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Tal Hagerstown Wa

7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Washington County Washington County Hospital 5. Social Security Number 6. Sex Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 KF 97 12, Director 220-54-1859 1906 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Mathema Emergence. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 TYes 2 No Maryland Washington Directo Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 163 Dartmouth Drive 21742 U.S.A. Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Cusick Jessica Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 163 Dartmouth Dr. Hagerstown, Maryland 21742 Jean M. Yost/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cabriels Cemetery Mar. 25,04 Potomac Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Douglas A. Fiery Funeral Home runcho 1331 Fastern Blvd. N. Hagerstown, Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** day 71 85012 6404 /Medical Due to (or as a consequence of): Examiner RSB phlumon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed should be detached for use as the burial-transit Due to (or as a consequence of): attending physicien and Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2 10 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.
To the Funaral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 70 n/l 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 2004 Registrar

			For State Registrar	State of Maryland / Depa		lental Hygie	•	12496
	Physici /Medic Examír	al	Decedent's Name (First, Middle, Last) JOHN ALLEN WINEB 4a. Facility Name (If not institution, give s 2414 KINDERBROOK	BRENNER JR.	4b. City, Town, or Location of Death	2. Date of Death Month APRIL 3		
	Funeral Director		5. Social Security Number 6. Sex 219-44-0059 Usual Residence of Decedent	7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)	ff Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y		plece (State or Foreign intry) YLAND
	he Maryland 18e-f show otified at	ector	MD 10b. County PRINCE G	GEORGES 10c. City, Town or Lo				10d. fnside City Limits 11 Yes 2 □ No
9	be filed within 72 hours after death with the Maryland nat Hygiene. Id other than "natural", or Items 23a or 28e-f show event, the Medical Examinar must be notified at	Funeral Director	10e. Street and Number 2414 KINDERBROOK 11. Marital Status 1□ Never Married 2☒ Marned	12. Was Decedent Ever in U.S. Armed Forces?	10f. Zip Code 20715 Was Decedent of Hispanic Origin? (Spit Yes, specify Cuban, Mexican, Puerto		USA 14. Race - Ameri Black, White,	can Indian, , etc.
Maryland 21215-0036	within 72 hours and. In matural, c	Completed by	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade) Elementary/Secondary (0-12)	cation e completed) Coffege (1-4or 5+) 16a. Decer (Give life.)	1 ☐ Yes 2 ☒ No Specify: dent's Usual Occupation kind of work done during most of work DO NOT use retired) OOL TEACHER	ing	Specify: WI bb. Kind of Business/Ir COUNTY S	,
yland 2	be filed ital Hygirid other event, I	To Be Co	17. Father's Name (First, Middle, Last) JOHN ALLEN WINEBR	RENNER	18. Mother's Name MARY EL	e (First, Middle, Ma IZABETH K	uiden Sumame) KUNKLE	
e, Mar	1 and 2 Health a em 27 is ther tree		19a. Informant's Name/Relationship (Type PATRICIA WINEBRENN) 20a. Method of Disposition	NER/ WIFE 2414	ng Address (Street and Number or Rura KINDERBROOK LANE sistion (Name of	BOWIE,		
Baltimore,	permit. Pages Department of I Important: If it any injury or o		1 ☐ Burial 2 ☒ Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	lemoval from State HUNTT CRE	matory or other place)	/2004 ERT E. EV	WALDORF, N	MD AL HOME
Physician /Medical Examiner	te be execu- ysician and le burial-tran	Icai Examiner	23a. Part1. Enter the disease, or compile shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	er the mode of dying, such as cardiac of Myclimac and a continue	or respiratory arrest		Approximate Interval Between Onset and Death
P.O. Box 68	death certifica e attending ph id for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delive	ery Day Year
ords, P.	Physicien: The law requires that the this certificate has been signed by the tail director, page 2 should be detach		Part II. Other significant conditions con	ntributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobad	cco use contribute to the	he cause of death?
tal Reco	icien: The law r certilicate has be rector, page 2 sh	Completed	25. Was case referred to medical				prior to co	opsy findings available impletion of cause of 2 No
Division of Vital Records,	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	ation; To Be	examiner?	lospital: 1 Inpatient 2 ER/Outpatien 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury			ee 6 Other (Specifinjury occurred	(y)
Divis	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
	To the Hospitel within 24 hours a To the Funerel completely filled	Medical	one) 2 Medical Examin	sician: To the best of my knowledge, death ner: On the basis of examination and/or inv and manner stated.	estigation, in my opinion, death occurre	ed at the time, date	and place, and due to	the cause(s)
)	Mill To	«	29b. Signature and title of certifier 30. Name and addr-ss of person who core	mpleted cause of death (Item 23a) (Type,	29c. License number Doo425		Date signed (Month,	2004
	Sta		22 Sowth Grand	32. Registrar's Signature		Ashraf	Z. Badros	
	Registr	ar	חות עוני	PROGRAM AS				

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ORIGINAL

UNK 04-118	. For		k Indelible Ink. Ensure A l Department of Health and M	_	
04-2388 AKG	1 - State Registrar		Certificate of Death	Reg.	No. 2004 12491
Physician /Medical	Dronda	n Marie Xenidis		2. Date of Death Month April 7	Day Year 3. Time of Death 2004 9:00 Δ
Examiner		street and number)	4b. City, Town, or Location of Death	1	4c. County of Death
	Elk River and C &		Chesapeake City		Cecil
Funeral Director	222-48-9864	TM office	rthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye OCT 22, 1	9. Birthplace (State or Foreign Country) 962 Delaware
and	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location		10d. Inside City Limits
death with the Maryland ms 23e or 28e-f show tribust be notified at meral Director	Delaware New Cas	tle Dela	ware City		1 ∑ Yes 2 ☐ No
Mith II	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
eath seath	219 Washington St		19706		United States
036 urs after are the	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
2 ho 2 ho teature	15. Decedent's Edu	ucation 16a	Decedent's Usual Occupation	16b	. Kind of Business/Industry
21215-00 ed within 72 hou ygiene. Ser than 'natura it, it a Madical E. Completed	(Specify only highest grad	College (1-4or 5+)	(Give kind of work done during most of work) life. DO NOT use retired)	ng	,
Con Con Con Con Con Con Con Con Con Con	12	10.12	Homemaker	In	Her Own Home
De fit de out			18. Mother's Name	(First, Middle, Maid	den Sumame)
Yla nould I Men narke natic		.	Doris Da		
Mal d 2 st th and 7 is n traun	19a. Informant's Name/Relationship (T)		Mailing Address (Street and Number or Rura		
Heall ther	Theodoros Xenidis	20b, Place of	O. Box 564, Delaware		Laware 19706 Location - City or Town, State
Pages nent of int: # lit	1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State Grace	r, crematory or other place) lawn Memorial April 2004	. 13,	
Baltimore, permit. Pages 1 at Department of Head Important: # flem any injury or other	21. Sign ture of Funeral Service Licens		22. Name and Address of Facility HICKS HOME for Fune:	rals, P.A.	w Castle, Delaware
	23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	lications that caused the death. Do	103 W. Stockton Strong enter the mode of dying, such as cardiac of	r respiratory arrest,	Approximate
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)	a. Muttyle (1) Due to (or as a consequence	wing Conglicated &	by Brown	Interval Between Onset and Death
Examiner jacks	Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	of):		/
68760, 7£ ifficate be executed tg physician and as the burial-transit	resulting in death) Last	Due to (or as a consequence of	of):		
of Vital Records, P.O. Box 687(Physician: The law requires that the death certificate the secretificate has been signed by the attending physical director, page 2 should be detached for use as the transfer of the second provided by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ds, Puires that signed to detail do be detailed by Pl	Part II. Other significant conditions con	ntributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☑Únknown
w requi				24a. Was an	24b. Were autopsy findings available
Division of Vital Records, or Attanding Physician: The law requires tatler death. Director: After this certificate has been signe in by the funeral director, page 2 should be certification; To Be Completed by	25. Was case referred to medical			autopsy performed? 1 A Yes 2 □ N	prior to completion of cause of death?
f Vita vysician: is certific director,	examiner?	lospital: 1 ☐ Inpatient 2 ☐ ER/Out	26. Place of Death patient 3□ DOA Other: 4□ Nursing Hom		о Пои о
After fune	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. T	ime of 28c. Injury at 2	8d. Describe how in	or scene
Vision Attending or death. Fector: After by the fune tiffication	2 Accident Investigation 35 Suicide 6 Could not be determined	28e. Place of Injury - At home, far	7	8f. Location (Street	and Number or Rural Route Number
Divinital or rs after all Direction led in I	Tiomold	building, etc. (Specify)	over coral	WER + Cheson	whitelevener From EUR
Division To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificat	29a. Certifier 1 ☐ Certifying Physical (Check only one)	sicien: To the best of my knowledge ner: On the basis of examination and and manner stated.	, death occurred at the time, date and place, a d/or investigation, in my opinion, death occurre	nd due to the cause(d at the time, date a	s) and manner as stated? Maryland and place, and due to the cause(s)
To the within 2 To the comple	29b. Signature and title of certifier	1.16	29c. License number	29d. D	ate signed (Month, Day, Year)
	7 hodre U	Kingness	O.C.M.E.	A	pril 8, 2004
1	30. Name and address of person who co				
4	THEODURE M. K., 31. Date filed (Month, Day, Year)		111 Penn Street,	Baltimore	Maryland 21201
State Registrar	APR 1 3 2004	32 Registrar's Signature	Scorle		

			1- State of Maryla	ind / Dep	artment o	of Health ar	nd Mental Hyg	iene 200	4 12492
2 - 2		Ų,	Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
460	Physici /Medic		Edwin Andr e w Yaniga, Sr.				April		4 9:30 P ^M
	Examin		4a. Facility Name (If not institution, give street and number)			vn, or Location of (Death	4c. County of Deat	
49.		í	Anne Arundel Medical Center 5. Social Security Number 6. Sex 7. Age (In yr	s. last birthday,	Annapo		Hrs. 8 Date of Birth	Anne Aruno	
1	Funeral Director		157-14-8253 1X M 2□F 79	Yrs.			Min. 8. Date of Birth (Month, Day, No v . 2 .		hplace (State or Foreign untry) Jersev
	D		Usual Residence of Decedent				110 0 . 2 ;	1724 NCW	*
	arylar show	<u>-</u>		City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2 X No
	the M	Funeral Director	Maryland Anne Arundel Anna	apolis	10f. Zip Co	de	16	og. Citizen of What Co	
	with Sa or	i Dir	6 First Street Greenwood Acres	2	21401			nited State	·
	death	nera	11 Marital Status 12. Was Decedent Ever in				n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame	ncan Indian,
ထ္	after or Ite	Ful	1 Never Married 2 Married 1 Married 1 Never Married 2 Married 1 Never Married 2 Never Married 1 Never Married 1 Never Married 2 Never Married			No Specify:	rueno Hican, etc.)	Black, White Specify: Wh	
8	ural',	d by	Year or Dates:						
Maryland 21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Items 23e or 28e-f show the Modical Examiner most be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual O e kind of work d DO NOT use n	one during most o	f working	16b. Kind of Business/	Industry
712	l withi	шо	Elementary/Secondary (0-12) College (1-4or 5+) 5 +	Teach		,	1	eaching	
פַ	e filed at Hygin other vent.	Be C	17. Father's Name (First, Middle, Last)			18. Mother's	Name (First, Middle, M		
/lar	should be and Mental a marked o	ToE	Steven Yaniga			Eleano	r Loepolski		
lan.	2 sho		19a. Informant's Name/Relationship (Type, Print)		,	reet and Number o	or Rural Route Number,		Tip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Show Interpretable to the than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Munical Examiner must be notified at ance.		Mary Patricia Lockett / Daughte		Atlant			Ocean City,	
סר	Pages nent of h int: If ite iry or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cre	matory or other	rplace)		•	
Baltimore,	artme artme ortant injury		* 4 Donation 5 Other (Specify) 21. Signature 47 Fuyiral Service Lines	wisvil	le Vet.	Cerr. 4/	CONTRACTOR CONTRACTOR CONTRACTOR	ownsville,	
Ba	permit. Departr Importa any inje		VIII AND STATE			,	John M. Ta		ral Home, Inc.
£.	N.		23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	ath. Do not en	ter the mode of	dying, such as ca	rdiac or respiratory arre	st,	Approximate Interval Between
	Physician	8 8	Immediate Cause (Final disease or condition	2/17	nenur	161	24611)		Onset and Peath
	/Medical		resulting in death) a. Due to (or as a const	equence of):	10 1 101	7	T COLO		1000
1	Examiner	L	Sequentially list conditions, b.		10	/			
	ed sit	Examiner	Sequentially list conditions, flary, wadmy to in mediate cause. Enter Underlying Cause (Disease or injury	aquenda "fi).					
	xecut and ul-tran	хап	that initiated events c. resulting in death) Last Due to (or as a const	equence of):					
760,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	caiE	d.						
89	ifficate g phy as the								
Вох	Attending Physicien: The law requires that the death certifical act death. act of adh. by the function of the certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fe		⊒Ectopic pregn	ancv		23d. Date of deli	*
П	e deal he att	sicis	1 Yes 2 No		Other (specif			Month	Day Year
<u>о</u> .	d by t	Phy	9 Unknown Part II. Other significant conditions contributing to death but not re	oculting in the	and orbing source	o grupe in Part I	23e Did tob	acco use contribute to	the cause of death?
ds,	signe d be c	d by	Renal failure	ssutting in the t	andenying caus	e giveirii Faiti.	1 □ Ye		bably 4 Unknown
Sor	v requ	etec					24a. Was an		topsy findings available
Rec	2 5 8	шр					autopsy perform	ed? prior to o	ompletion of cause of
Vital Records,	sicien: The law certificate has b irector, page 2 s	a)	25. Was case referred to medical			26 Place of	1 ☐ Yes 2 Death (Check only one	7.10	2□ No
<u> </u>	ysicie is carl diract	0 B	examiner?	☐ ER/Outpatie	nt 3 DOA	Other	ng Home 5 ☐ Resider		ify)
0 0	ng Phys Iter this neral di	J: L	27. Manny of Death 1 Natural 5 Pending (Month, Day Year)	28b. Time o	of 28c.	Injury at Work?	28d. Describe how	w injury occurred	
sio	tendii leath. tor: A the fu	catio	2 Accident investigation			1 Yes 2 No			
Division of	or At after d Direct in by	Certification:	4 Homicide determined 28e. Place of Injury - At building, etc. (Special Control of the Control o	home, farm, st cify)	reet, factory, of	fice	28f. Location (Str. City or Town,	eet and Number or Ru. State)	ral Route Number,
_	spitel		29a. Certifier 1 Certifying Physician: To the best of my k	nowledge, dea	th occurred at the	ne time, date and r	place, and due to the ca	use(s) and manner as	stated
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only 2 Medicel Examiner: On the basis of examinant and manner stated.	nation and/or in	nvestigation, in	my opinion, death	occurred at the time, da	te and place, and due	to the cause(s)
	To th withir To th comp	×	29b. Signature and title of certifier		29c. Li	cense number	29	d. Date signed (Month	Day, Year)
			In Whomen w	D	1	13844		04/04/	04
			30. Name and address of person who completed cause of death (It	ет 23а) (Туре	Print 1	29.	Ann	m	n
	- 64		31. Date filed (Month, Day, Year) 32. Registrar's Sig	nature	1 11/1-1	J VIVE	1111111100	115 1 11))
	Sta Registr		APR 0 5 2004	No Miles	South.		•		

		1	State of Maryland / Department of Health an				
			- State Registrar Amend#5perFH/FCHD/SL/4-15-0@ertificate of Death 1. Decedent's Name (First, Middle, Last)	2. Date of De	ath	004	3 Time di Dean 3
	Physicia		Beryl Louise Young	April	4 Day 2	0 0 4	5:17 P M
5	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of l			ounty of Death	3.17 1
	Examili	er	Frederick Memorial Hospital Frederick		Fr	ederio	ck
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Min (Month, Da	h v, Year)	9. Birthi	plece (State or Foreign ntry)
	Director	-	200-24-8132 ₂₀₀₊₂ 4-8408 71 Yrs.	July 22	, 193	2 Penn	sylvania
	pug *	-	Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Aaryli f sho	5	Maryland Frederick Frederick				Yes 2 No
	28a-	Director	10e. Street and Number 10f. Zip Code		10g. Citize	n of What Cou	ntry?
	72 hours after death with the Maryland Inatural; or Items 23a or 28a-f show Vical Exurgian must be motified at	Ö	320 Queen Street 21701		U	.S.A.	
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin Marmed Forces? 13. Was Decedent of Hispanic Origin Market Status	in? (Specify Yes or No Puerto Rican, etc.)	- 14	Race - Ameri Black, White,	
9	or ite	F	1 Never Married 2X Married 1 1 Yes 2 No If Yes. Give 1 Yes 2 No Specify:		S	_	ite
8	ural',	d by	3 Widowed 4 Divorced Year or Dates: 15 Decedent's Education 16a. Decedent's Usual Occupation		16h Kind	of Business/In	oduetry
15	"nat	Completed	(Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired)	of working	TOD. MITO	Of Dusinessyn	dustry
12	within lene. than "	mo.	Elementary/Secondary (0-12) College (1-4or 5+) Cafeterian Worker		Pub1	ic Scho	ols
b	illed Hygie other	Be C		s Name (First, Middle	Maiden St	лтате)	
Jan	Aenta Aenta rked tic ev	To B	William McKinley Vaughn Ele	sie Schock			
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, The Martical Expression in the incitified at		19a. Informant's Name/Relationship (Type, Print) Ray Young, Jr Husband 19b. Mailing Address (Street and Number 320 Queen Street,				o Code) 21701
	1 and 2 Health Iem 27 i			Date		tion - City or T	
Baltimore,	ges 1 It of P If ite or ot		t ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State				
Ħ	permit. Pages 1 and Department of Heali Important: if item 2 any injury or other once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility			ick, Ma	
Ba	permi Depa impo any ir		MAKON CAMILLO CO VILLO 1621 Opossumtown				
			23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca				Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition —	-Aprtiz	Valu	14	Onset and Death
	/Medical		disease or condition resulting in death) a	101	.,		you
ġ.	Examiner		Sequentially list conditions, b.				
	pi ii	iner	Taily, leading to immediate cause. Enter Underlying Cause, Disease or injury				
	and and I-trans	Examine	Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of):				
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and to has 2 should be detached for use as the burial-transit	E III					
687	ficate p physis the	edicai	0.				
Box	eath certific attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23	d. Date of deliv	
	death e atte	icia	in the past 12 months? 1 Yes 2 Other (specify)			Month	Day Year
P.0	at the de by the a	hys	9 Unknown	02 - Did			the serves of death?
	es tha igned be del		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did i	1		the cause of death? bably 4 □Unknown
Records,	w require been si should I	Completed by	2111111111				
3ec	e taw has b	mple	Diabetas 19911/195 - 5424 11	24a. Was	osy ormed?	prior to co	opsy findings available ompletion of cause of
alF			Atrial tibrillation	1 ☐ Yes	2000	1 🗆 Yes	2 🗆 No
Vital	Physician: this certific ral director,	o Be	avaminar?	of Death <i>Check onl</i> of Sing Home 5 ☐ Resi		Other (Speci	ifu)
of		-	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe			,
ion	ttending F death. ctor; After ; the funer.	atio	Month, Day Year) Injury Work? 2 ☐ Accident investigation (Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ N	io			
Division	I or Attending after death. Director: After I in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (City or To		Number or Rur	al Route Number,
Ö	ital or A irs after rai Direc						
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) To the best of my knowledge, death occurred at the time, date and (Check only one) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death and manner stated.				
	o the ithin 2 or the	Med	29b. Signature and title of certifier 29c. License number		29d. Date	signed (Month,	, Day, Year)
	F 3 F 8		MDD16428		41	6/06	f
	0	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			1-0	
	S		Casper E. Cline, II - 300 W. Ninth Street, Frederi	ck, Maryla	nd	21701	
44		ate	31. Date filed (Month, Day, Year) APR 0 9 2004 32. Registrar's Signature				
	Regist	di	MEN O CULA A				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - Stata Registra Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 50 90 /Medical 4c. County of Death institution, give street and number) 4b. City, Town, or Location of Death 4a. Facility Name (If nor **Examiner** Kildeer Grav 1501 -ane 8. Date of Birth
July 193, Year 920 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 Ū F 83 217-42-6819 Vrs Pennsylvania Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Grantsville 1 ☐ Yes 2 No Garrett MD Completed by Funeral Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21536 39 Killdeer Lane 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Retail Book Store Manager 8 th i. Pages 1 and 2 should be filed vitnent of Health and Mental Hygien tant: if item 27 is marked other tigury or other traumatic event, III. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lucy Miller Moses Beachy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 344 Hemlock Drive, Grantsville, MD 21536 Eli M. Yoder/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State View Cemetery, April 5, 2004 Salisbury, PA Department or Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Newman Funeral Homes, P.A., PO Box 275 uma 179 Miller St. Grantsville, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** oronary V16 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner and I-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician ar Division of Vital Records, P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown signed by t d be detach Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Yes 2 No 1 Yes 1 ☐ Yes o the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Yes 2 No this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1_Natural 5 Pendina death. 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 | Homicide within 24 hours after To the Funeral Dire 💶 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/200

State

Registrar

au

ORIGINAL

of death (Item 23a) (Type, Print)

ev

32. Registrar's Signature

30. Name and address of person who completed caus

APR

5 2004

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Maryla	nd / Dep	artme		ith and M	lental Hy	giene		10105
			Hegistrar 1. Decedent's Name (First, Middle, Las	*1		Timea	ie oi bei	alli	2. Date of De	Reg. No	<u> </u>	171393
	Physic	ian	1. Decedent's Name (First, Middle, Las	1)					Month	Da	Yeer	3. Time of Death
· Comp	→ /Medi		Rose You	ng					APRIL	-	2004	
-	Exami	ner	4a. Facility Name (If not institution, give		4.4	100	, Town, or Loca			4c.	County of Dea	ath C4
		mi.	NERTH ARMON	EL HOSRY	AL	13924	en fsu					AREMEDEL
	Funeral Director		5. Social Security Number 6. Sec. 1 218–42–1643	7. Age (In yrs	. last birthday) Yrs.	Months Months		Jnder 24 Hrs. ours Min.	8. Date of Bir (Month, Da Nov. 1	th y, Year) 2 1	9. Bi	rthplace (State or Foreign Sountry) Arvland
	_		Usuat Residence of Decedent						1101. 1		3 1 1 110	aryrana
	ytan		10a. State 10b. County	10c. C	ity, Town or L	ocation						10d. Inside City Limits
	Mar	to	Maryland Anne A	rundel Cr	ofton							1 XYes 2 No
	r 28s	Director	10e. Street and Number	I dilaci Ci	OF COIL		ip Code			10g. Cit	izen of What C	country?
)	3a o	0	1610 Kent Fort	Tano			21114	1			USZ	
•	death with the Maryland ms 23a or 28a-f ahow [must be nutified at	era	11. Marital Status	12. Was Decedent Ever in I	J.S. 13.	Was Dece	edent of Hispan ecify Cuban, Me		cify Yes or No	- 1	14. Race - Am	
10	r Ita	Funerai	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2√∑No	j				Rican, etc.)		Black, Wh	
3	urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	XXX No Sp	ecify:			Specify:	Black
21215-0636	72 hours after netural', or Ita	Completed	15. Decedent's Ed		16a. Dece	dent's Usi	ual Occupation			16b. Ki	nd of Business	s/Industry
7	within 7 ene. than "n	pie	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	ork done during use retired)	most of worki	ng			
2	filed with Hygiene. Ither than	E O	12th	0	Custo	mer	Servic	re Rep		Αt	ድሞ	
	e filed I Hygie other	Be	17. Father's Name (First, Middle, Last)		7.5				(First, Middle,			
a	Mental Mental arkad o	To E	Oliver Sc	ott				Ida	McKee			
Maryland	and Manales ma		19a. Informant's Name/Relationship (T		19b. Marti	ng Addres	s (Street and N	lumber or Rura	I Route Numbe	er, City o	r Town, State,	Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 ahow any injury or other treumatic avant, the Marical Examiner must be inclined at angle ing.		James C. Young	(Husband)	161	0 Ke	nt For	t Lan	e Crof	ton	, Md.	21114
ē,	of Hez		20a. Method of Disposition	I	Place of Dispo	osition (Na	ame of	0	ate	20c. Lo	cation - City or	Town, State
Baltimore,	Pages nent of nnt: If its nry or o		1 ☐ Burial 2 ☐ ☐ remation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	tro C			4/1	2/04	Ba1	timore	e, Md.
≣	permit. Page Department c Important: If any injury or once.		21. Signature of Funeral Service Licens				nd Address of F		-			
Ba	permit. Departr Imports any inj		Hanny H. A	Deane 1100 48			eese &		Mortu	ary	, P.A.	
	15 380		23a, Part 1. Enter the disease, or comb	lications that caused the dea	th. Do not en	Z] W ter the mo	est St de of dvina, sud	Anna ch as cardiac o	apolis r respiratory ar	rest.	d. 214	Approximate
			shock, or heart failure. List only of Immediate Cause (Finat	ne cause on each tine.								tnterval Between Onset and Death
The second	Physician /Medical		disease or condition resulting in death)	a HTrofic		Zre	HALO?	4747				
	Examiner			Due to (or as a conse	quence or):	250	204 6	Siera	3=/2			
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	ted	ni u	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	CNOSINE	22.4	10	faring.	CG				
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ox 6	ding se as	Physician/Med	tF FEMALE:	23c. If yes, outcome of pregn	anov							
Во	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fet	al death 3	Ectopic p				2	3d. Date of de Month	tivery Day Year
o.	the d	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown	Jean 5	Other (s	рөспу)					
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Records,	signed be det	1 by				, , ,			T		DNo 3□Pi	
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şe.	has yes	ф							24a. Was autop	SV .	24b. Were at prior to	utopsy findings available completion of cause of
		S							1 ☐ Yes	med/? 2 ☑ No	death? 1 ☐ Yes	2 Ø No
Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hamilton /				Place of Death	(Check only of	ne)		
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	ng fter	no.	27. Mann→r of Death 1 Shatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of tn j ury		28c. Injury at Work?		8d. Describe h	ow injury	occurred	
Sign	ten leat tor: the	cat	2 Accident investigation 3 Suicide 6 Could not be			М	1 🗌 Yes					
Division	l or Attendi after death. Director: A I in by the fu	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str fy)	eet, factor	y, office	2	8f. Location (S City or Tow	treet and n, State)	l Number or Ri	ural Route Number,
	urs a aral [20 2 3 3 3	1								
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medicel Exami	sician: To the best of my kniner: On the basis of examination	owledge, death ation and/or in	n occurred vestigation	l at the time, da n, in my opinion	te and place, a , death occurre	nd due to the old at the time, o	ause(s)	and manner as place, and due	s stated. to the cause(s)
	thin the mple	Med	29b. Signature and title of certifier	and manner stated.			c. License num					
	F 3 F 8		GIX)	Δ	18		5451			Su. Dale	signed (Mont	n, vay, rear)
			- West	1					7	10	(0)	1004
			30. Name and address of person who d	peopleted cause of death (Itel	n 23a) (Type	Print)	d El	YEM BI	Uynie	MI	> 2-10	100
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regerrar's Sign			81		- , - , -	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		•
	Registi			2004		Some	80					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARCH 21, Day 2004 BENJAMIN ZTTOMER 9 00 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Month Ray. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country) 1 XM 2 ☐ F JANUARY 3 85 1919 Director 577-14-1938 Usuel Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or gither traumatic event, the Medical Examiner must be indifficult at once. 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits Directo Y☐Yes 2☐No MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14508 HOMECREST ROAD 20906 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑Yes 2 ☐ No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes X No δ UNKNOWN Specify Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etementary/Secondary (0-12) Coltege (1-4or 5+) REPORTS ANALYSIST U. S. GOVERNMENT 12 YEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HYMON ZITOMER MARY TOUVELT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER MARILYN FINE 907 HOYT STREET SILVER SPRING MARYLAND 20902 20b. Place of Disposition (Name of EZRAS I SKAEL: CONG. SEC. NAT L CAPITOL HEBREW 3/23/2004 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) CAPITOL HEIGHTS, MD. 21. Signature of Funeral Service License DANZANSKY GOLDBERG MEMORIAL CHAPELS, INC. Donald (. cottles 1170 ROCKVILLE PIKE ROCKVILLE MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each like. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of): Examiner ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) death certificate be executed burial-transit ACUTE RENAL FAILURE and Due to (or as a consequence of): Box 68760 ASPIRATION PNEUMONIA Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant atten 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. detached Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by should be DEMENTIA 2 **X**No Completed 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? (es 2**0** No 1 Yes 2 No 1 Yes Physicien: director, Be 25. Was case referred to medicat 26. Place of Death (Check only one) examiner? Hospital: 1 Npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death After t Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 🕅 Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after 4 Homicide within 24 hours a To the Funeral D To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check o 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 10 D-59284 MARCH 22, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1299 LAMBERTON DRIVE, SILVER SPRING, MARYLAND 20902 DR. SHAMIM. SHAHID 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State 29 MAR 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** 2004 ZICKEFOOSE APRIL 2357 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSDITA If Under 1 Year If Under 24 Hrs. 8 acred Heart 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Days Hours Min. 1 □ M 250 F Yrs. Director 70 384-34-7650 Michigan Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. The file of 23 or 28a-1 show other traumatic event, the Marklad Expris an intuitive notified at Director 1 ☐ Yes 2 ☑ No Garrett Swanton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 556 Pauls Lane Funeral 21561 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☑ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest HULL Cora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Pages 1 and 2 slowthment of Health and crtant: If item 27 is r Diana Goller/daughter 556 Pauls Lane, Swanton, Md. 21561 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ō * 4 ☐ Donation 5 ☐ Other (Specify) Garrett Co. Mem. Gdns. 4/6/04 Oakland, Maryland 22. Name and Address of Facility Stewart Funeral Home mpo 32 S. Second St., Oakland, Md. 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CONCESTIVE HEART about disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as the t IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 PNo Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ MBLUTUS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? ANEMIA 1 Yes 1 ☐ Yes 2 ☐ No 25 No 25. Was case referred to medical 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After Hospital or Attending 1 SNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after death uneral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a e Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 26907

Registrar

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DHMH 17 Rev 1/2001

SIDHU 925 BISHOPWALSH ROOD COMBERBUD, ND 21502

Holle

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Harrit 31. Date filed (Month, Day, Year)

APR -

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regiŝtrar's Signature

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of rtificate o	f Health a of Death	and Me		giene	104	12499
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500	Examir		4a. Facility Name (If not institution, Baltimore Rehab	we street and number,	ondodCare	Ba		ore			ty of Death	
2	Funeral Director		5. Social Security Number 097 14 9680 Usual Residence of Decedent	. Sex 7. A	ge (In yrs. last birthday) 79 Yrs.	If Under 1 Ye Months Day		Min.	B. Date of Bir (Month, Da 8/2/19	924	9. Birthp Coun PA	lace (State or Foreign try)
	n the Maryland r 28a-f show notified at	ctor	MD Baltim	ore	10c. City, Town or Lo Rosedale						1	0d. Inside City Limits 1 ☐ Yes 2 No
	ath with th s 23a or 26	ral Director	1926 Ellinwood			10f. Zip Cod	144			10g. Citizen o USA		
920	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Modical Examination and be motified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' DXYes 2 ☐ If Yes, Give T Year or Dates'	No No	Was Decedent of If Yes, specify C		gin? (Spec i, Puerto R	ify Yes or No ican, etc.)	Spec	ace - Americ lack, White, hity: WHi	etc.
Baltimore, Maryland 21215-0036	within 72 hours ene. than "natural", he Madical Ex.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		(Give	dent's Usual Oci kind of work do DO NOT use ret	ne durina most	t of working	7	16b. Kind of Machin		dustry
land 2	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, IDE M.	To Be Co	17. Father's Name (First, Middle, La Samuel Amato	st)	120011			r's Name (Lipar		. Maiden Suma	ame)	
, Mar	1 and 2 sho Health and N em 27 Is ma sther trauma	•	19a Informant's Name/Relationshi Hattie M. Amato	(Type Print) Wife	1926	ng Address (Stre Ellinwo	ood Rd.	Rosec	lale Ma	aryland	21237	/
timore	Pages nent of ant: If it		20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)	Metro Cr	ematory or other p	olace)	/23/C		20c. Location Caton	- City or To SVill∈	
Bal	permit. Departn imports any inju		21. Signature 21. Signature 22		. 1	2. Name and Add 211 Ches	saco Av	enue			uneral ryland	Home 1 21237 Approximate
	Physician /Medical		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. Car	ine. C NO MA s a consequence of):		Pros			iresi,		Interval Between Onset and Death Years
8760,	Examiner hysician and hysician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):	U						
O. Box 6	The law requires that the death certificate to has been signed by the attending physoge 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death 3	Ectopic pregnal					ate of delive	ry Day Year
Q _	w requires that been signed b should be dete		Part II. Other significant condition		out not resulting in the u Hailure	nderlying cause	given in Part I.		23e. Did to			e cause of death?
Vital Records,		Completed by									prior to con death?	psy findings available appletion of cause of
of	fing Physician:	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga	Hospital: 1 Inpati		28c. in	Other: 4 Nur	rsing Home		dence 6 00)
Division	i Ditt	Cer ification:	3 Suicide 6 Could no determin	28e. Place of in building, e	jury - At home, farm, str ic. (Specify)	eet, factory, office	се	28	f. Location (\$ City or Tox	Street and Num wn, State)	ber or Rural	Route Number,
	To the Hospital or Ai within 24 hours after or To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	of my knowledge, death of examination and/or in ated.	vestigation, in m	y opinion, deat	d place, and	at the time,	date and place	, and due to	the cause(s)
	To the within 2 To the complex	Σ	29b. Signature and title of certifier C 30. Name an address of person wi	all,	death (Item 23a) (Type, och Raver rar's Signature	29c. Lice 3 4	4359	(0)	410)	29d. Date sign	ed (Month, E	Oay, Year)
	Sta	te	John S. LAH M. 31. Date filed (Month, Day, Year)	D 3900 L	och Raver rar's Signature	Boule	rard,	Balt	tim ors	e, Mary	land	21218
	Registi	ar	APR 2 2 2004	Dens	N M	JOERS						

IJ			1 - For State Unpend Item#23e	State of N h-b,27,Per I	Maryland / ME,G830,4	Depa /28/ 24	rtment <i>Mcate</i>	of He	ealth a Death	and M	lental Hy	gien Reg. No	201) 4	125	00
			Decedent's Name (First, Middle, Las								2. Date of De			Value	3. Time o	of Death
	Physici		John Neale Burroughs								April	14		2004	9:56	P M
	/Medic Examin		4e. Fecility Name (If not institution, give				4b. City, To	own, or l	ocation o	of Death						
1			17 Georgetown (Annapolis					Anne Arundel							
Funeral Director			5. Social Security Number 6. Social Security Number 1.3-70-8251	9x M 2 ☐ F 7. Age (In yrs. last birthday, yrs.			it Under 1 Year If Under 24 Hrs. Months Days Hours Min.			8. Date of Birth (Month, Day, Year) NOV 9, 1956		56	9. Birthplace (State or Foreign Country) MaryLand			
	P.		Usual Residence of Decedent		10. 0. 7											
	how		10a. State 10b. County	1 1	10c. City, To	own or Lo		-						10	0d. Inside C	ity Limits
	8a-f	cto	Maryland Anne Ar	.uide1			Annapolis									
Maryland 21215-0036	h with th	ai Directo	10e. Street and Number 17 Georgetown C	ourt			104. Zip Code 21403				10g. Ci	tizen of V	Vhat Coun SA	try?		
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Menial Hygiene. If item 27 is marked other than "neturel" or itama 23e or 28e-f ehow or other traumatic event, the Madical Examiner must be notilized at	by Funeral	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:		"	Was Decedent of Hispanic Origin? (Specify Yes It Yes, specify Cuban, Mexican, Puerto Rican, etc				ncify Yes or No Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White				
5-0	72 hc	Completed by	15. Decedent's Ed (Specify only highest gra		16	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)			t of workii	ng	16b. H	. Kind of Business/Industry				
121	within ene. than	duc	Elementary/Secondary (0-12) College (1-4or 5+) Waiter						I	Restaurant						
d 2	Hygie other	Be Co	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle					
/lan	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Me	To B	Percival E	lliott Bu	rroughs	3				Eli	izabeth	Nea	ale			
lan	2 should and Men is marke		19a. Informant's Name/Relationship (1								l Route Numb					
	1 and 2 Health tem 27		Thomas Elliott Bu	rrougns/r	- Pa		UZ S.		isbur		Lvd. Sa			MD 2		
or	Pages 1 nent of H int: If ite iry or otl		20a. Method of Disposition 1 Burial 2 Cremation 3		• Metro	tery crem	natory or oth	er place,	$\frac{1}{2}$	4/16/	′04			re, I		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 it any injury or other tra 900.08.		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Cicen	-	al D	22	Name and	Address	ot Facility	y 1 Ho	mag T		L C LINC	,10, 1		
_	89 2 2 9		Dawn F. Me	Dona1d	mer		0046 E	ark	stea	Roac	l Park	stey	, VA	2342		
	Physician /Medical	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac Arrhythmia Due to (or as a consequence ot):										Approximat Interval Bet Onset and	tween			
	cate be executed by system and ithe burial-transit		Con anti-th-tips and disings	Hypertensive Heart Disease												
ds, P.O. Box 68760,		ai Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):												
	death certifi e attending id for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal dea at time of death		Ectopic preg Other (spec						23d. Date Mor	e ot delive	,	Year
	es De ge	by	Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow							
Record	0 - 6	Completed	al pi								perfo	topsy prior to completion of cause of death?				
Vital	icien: Th certificate rector. pag	0	25. Was case referred to medical						26. Place	of Death	(Check only		<u> </u>			
of	d is	n: To B	1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								at sc	ene				
sior	Attending I ir death. ector: After by the funer	atio	1X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury Work? M 1 Yes 2 No					10							
Division	i ji fe e	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					2	28t. Location (Street and Number or Rural Route Number, City or Town, State)				nber,		
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 Medicel Exem	ysician: To the bes niner: On the basis and manner:	of examination.											5)
and manner stated. 29b. Signature and title of certifier 29c. Licens								icense i	cense number 29d.				I. Date signed (Month, Dey, Year)			
La leinelle +							O.C.M.E. Ag					Apri	oril 15, 2004			
(1 Brus		30. Name and address of person who can also a superior with the superior and address of person who can be superior as a superior and address of person who can be superior as a superior and address of person who can be superior as a superior and address of person who can be superior as a superior and address of person who can be superior as a superior and address of person who can be superior as a superior and address of person who can be superior as a superior and address of person who can be superior as a superior and address of person who can be superior as a superior and address of person who can be superior as a superior and address of person who can be superior as a superior and address of person who can be superior as a superior and address of person who can be superior as a superior and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person address of person and address of person and address of person address of	completed cause of	death (Item 23a			st:	reet,	, Bal	Ltimore	e, Ma	aryla	ind 2	1201	
	Sta Registi		31. Date tiled (Month, Day, Year) APR 2 2 20	All I	trar's Signature		12 M									

DHMH 17 Rev 1/2001

ORIGINAL

	Please	Type or Prin											
For State Registrar		State of Ma			rtment of H tificate of t			Mental Hy	/gie: Reg.		004	12	179
Decedent's Name	e (First, Middle, Las	st)						2. Date of D		D		3. Time of	
RAYMOND	CHARLES	BRIDGES						Marc	h	Day 8	Žα	14 14	5 AM
Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth													
ahrney-Keedy Home Boonsboro Washington													
Social Security N 220–10–7		ex 7. Age X M 2□F	e (In yrs. last birtl 85 Y	rday)_ rs.	Months Days	If Under Hours	24 Hrs. Min.	8. Date of B	irth ay, Ye	1 918	9. Birtl Co	nplace (S tate o <i>untry)</i> MARYLAN	r Foreign ID
sual Residence of	Decedent												
a. State	10b. County		10c. City, Town	or Loc	ocation						10d. Inside		
ARYLAND	RYLAND WASHINGTON					BOONSBORO						1 ☐ Yes	2X No
e. Street and Nur	mber			10f. Zip Code				10g. Citizen of What Country?					
8507 MAF		21713					U.S.A.						
. Marital Status 12. Was Decedent Ever in U.S., Armed Forces? 1944- If					Vas Decedent of Hispanic Origin? (Specify Yes or No- Yes, specify Cuban, Mexican, Puerto Rican, etc.)						14. Race - American Indian, Black, White, etc.		
1 Never Married 2 Married 1 TYPE 2 No.													
3 Widowed 4 □ Divorced Sear or Dates:				1	LITES 2AL NO	Specify:				Specif	y: .	WHITE	

tahrnei 5. Social Security Numb **Funeral** 220-10-7251 Director Usual Residence of Decedent 10a. State 10b. Count or 28a-f show MARYLAND WA Direct 10e. Street and Number 8507 MAPLEVILI or items 23a Funeral 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. If item 27 ie marked other than "natural; or item any injury or other traumatic event, the Medical Exemiter? 1 Never Married 2 Ma Completed by 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12CORRECTIONS OFFICER STATE DEPT. OF CORRECT. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EDGAR L. BRIDGES GRACE V. REAM 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAY A. KING, DAUGHTER 1929 MOUNTAIN CHURCH ROAD, MIDDLETOWN, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State BOONSBORO CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) MAR. 20, 04 BOONSBORO, MARYLAND Synapure of Funeral Service Land e 22. Name and Address of Facility 7606 OLD NATIONAL PIKE Party. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner

as the

use

ō

signed by the a

page 2

this

After

death. after death

completely filled in by the funeral dir

The faw requires that the death certificate be executed

To the Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Kaymond Charles Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

RAYMOND

a. Eacility Name (If not institution

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician ar

Physician/Medical

Completed by

Medical Certification: To Be

erman	BAST	FUNERAL	HOME	BOONSBORO,	MARYLAND	21713
plications that caused the death. Do no one cause on each line.	Right	of dying, such as	cardiac or r	espiratory arrest,	Inter	roximate val Between et and Death
b. Clyllyova(cv) Due to (or as a consequence of) Due to (or as a consequence of)	lay A	coide	nt		3	×
c. Congestive Due to (or es a consequence of)	Hear	1 Fa	ilay	re	2	<u> </u>
d						

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

Day Year

21769

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown 24a. Was an

autopsy performed? 1 Yes 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 254 No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 🖸 Accident 5 Pending investigation

28a. Date of Injury (Month, Day Year) 28b. Time of Injury 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 🗌 Suicide

4 - Homicide

fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier NO

052323

29d. Date signed (Month, Day, Year) 3/18/04

2HBH

within 24 hours a To the Funerel I

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHALID M. WASEEM, M.D.

1126 OPAL COURT, HAGERSTOWN, MARYLAND

State **Hagistrar** 31. Date filed (Month, Pay Year) 9 2004

32. Registrar's Signature

ORIGINAL